Ad Hoc Committee
on Child Mental Health

Report to the Director

NATIONAL INSTITUTE OF MENTAL HEALTH

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PREFACE

Shortly after his appointment as Director of the National Institute of Mental Health on June 3, 1970, Dr. Bertram S. Brown announced that mental health programs for children would be his No. 1 priority. In September 1970, Dr. Brown appointed an NIMH Committee on Child Mental Health to review the Institute's programs for children and youth and to suggest new and expanded efforts to meet the mental health needs of children. The Committee was given the charge to come up with specific recommendations that could be implemented in the next 12 to 18 months. In order to translate this priority into concrete programs, the Committee has met for 16 full afternoons and for two full-day sessions. In addition, six subcommittees have each held from five to ten meetings. Altogether, 60 members of the NIMH staff have been deeply engaged in this effort and more than 100 additional staff members have taken the time to submit ideas to the Committee for its consideration. They were useful, and the Committee is grateful for them.

The Committee divided itself into six subcommittees: Research, Training, Services, Prevention, Child Advocacy, and Financing. Naturally, these subcommittees had overlapping interests, since a mutually exclusive categorization of the child mental health field seemed impossible. For the same reason, the Committee report contains overlapping statements, and in some instances suggestions are repeated in more than one context.

Although the Committee has identified substantive issues and made specific recommendations, it must be emphasized that the report should be considered only a first step toward long-term development and expansion of NIMH programs related to children and youth. For even with hard-nosed management, the efforts recommended in this report will fall far short of the ultimate level of achievement that NIMH should set for itself as a Federal agency with key responsibilities for the Nation's most precious resource—its children and youth. To reach the desired mark we shall need increased appropriations, improved programs, new and different manpower, and new methods of management for integrating human service systems. Consequently, the Committee wishes to state in the strongest terms that NIMH should continue to exert the most powerful influence it can command within the Executive Branch, and subsequently in its defense of budgets before the Congress, to obtain additional resources for children's programs. In short, the Institute must be, in the Director's words, a "cooperative advocate" for child mental health.

Many of the recommendations can be implemented by NIMH without additional legislation or budgetary increases. As in any effective priority implementing process, however, this means that some other important activities will have to be foregone or curtailed. This report proposes mechanisms through which existing resources can be targeted for children's programs. It points out general purposes for which the available resources should be utilized.

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I. OVERVIEW OF APPROACH

"The Child is father of the Man." This line offers both a warning and a hope to us: A warning that adult mental illness often has its roots in childhood; a hope that our children will grow into responsible adulthood, able to cope with the world we will them and to seek answers to the problems we leave unresolved.

The decision to make child mental health the first priority of the National Institute of Mental Health reflects the desire to make this more than a pious hope. Institute programs have a great potential for the betterment of our children's mental health. By redirecting staff energy and program emphasis NIMH can help translate this hope into reality.

The Final Report of the Joint Commission on Mental Health of Children declares that our claim to being a child-centered society is a myth. The report points to not only the "miniscule" resources we as a Nation devote to services for children but also our failure to offer adequate help to families rearing children. Statistics give credence to the Commission's observations. In 1969, more than 900,000 of our children in the age group 10 to 17 were brought before juvenile courts. In 1968, 437,000 children were seen in outpatient psychiatric clinics, 33,000 were patients in public and private mental hospitals, 26,000 were in residential treatment centers, 13,000 in day/night services, and 52,000 were patients in community mental health centers. Almost 10 percent of our young people will have had at least one psychiatric contact by the time they reach 25 years of age. Thirty thousand children were battered or neglected in 1969, and those were only the ones we know about. Twenty thousand children were admitted to public and private mental hospitals and many of them, unfortunately, will spend years there. Not only have admissions to public mental hospitals doubled for persons under 25 years of age in the last 10 years but also the number of resident patients in this age group has continued to increase annually in spite of the fact that for older age groups the number of resident patients has continued to decline. Teachers of elementary school children feel that, on the average, 10 percent of the children they teach are "severely maladjusted" and "in need of professional help." The number of youths experimenting with illegal drugs has increased sharply in the past decade.

Contributing to these numbers but larger than any of them or the sum of them is the number of children that might be characterized as "deprived." Most come from families denied an equitable share in the Nation's wealth, all too often because of race. Such children differ from their middle-class counterparts not merely in the wealth possessed by their families but also—and this is where American health services have broken down—in the accessibility of help from service agencies. There is another form of deprivation, less widely recognized than that resulting from poverty or from racial discrimination,

which might be termed psychosocial. It is experienced by children—often from middle and upper income families—who live in a physical and interpersonal environment that is inimical to proper psychological, educational, and social development. Children suffering from deprivation, whatever its cause, and their families, need help as truly as those—and their families—clearly diagnosed as mentally ill.

NIMH must assume a leadership role in stimulating and, where necessary, creating mental health resources that will be responsive to those who most need help. The need to do more for our children could not be clearer.

Assumptions Underlying the Report

In analyzing how the Institute can improve its efforts to serve the mental health needs of all children, the Committee made two basic assumptions. Since these assumptions are often unstated in the discussions and recommendations of the report, they are set forth here with some elaboration.

A. *Viewing the Child within a Developmental Framework.* The first assumption is that the child should be viewed within a developmental framework. He should be treated not as a static individual who undergoes a sudden metamorphosis into an adult but as a developing, growing individual whose needs and strengths change with age.

The child is a continually evolving individual. The Committee urges that the changing nature of the child and the changing institutions influencing his development be borne in mind in implementing children's programs to assure that they meet the needs of children at different stages of the child's development.

Although all stages in a child's development have significant mental health implications, the Committee selected two periods as of particular importance: early childhood (0 to 6) and adolescence (13 to 20). The Committee selected early childhood as one period of major concern because it is the period in which foundations are laid for all future development. Further, the Administration as a matter of high priority has undertaken to expand efforts of the Federal Government to help children in this age group. The Committee selected adolescence as the second period of major concern because it often involves increased stress—brought about by the need to meet demands for achievement, independence, sexual identity, and vocational choice—and is marked by frequent intergenerational conflict, alienation, and experimenting with new life styles. For this age group suicide is the third most frequent cause of death and drug abuse a major medical-social problem. The Committee had another reason for selecting adolescents as a target group: The Institute—and, indeed, research and service agencies in general—has put fewer resources into studying and serving them. In consequence, less is known about the adolescent stage of development than about early childhood.

B. *The Child in His Total Environment.* The second major assumption underlying this report is that the child must be viewed within the context of his environment—as a member of a community, a neighborhood, a family. To help the child we must deal with his total "social ecology." The Joint

Commission stressed this when it said: "To promote the mental health of children and youth, we must also promote the well-being of their families and communities." Viewing children together with their families should not, of course, deflect our attention from children who have no families; their need for mental health and other services is often more acute.

The Requirement for Collaboration

To deal with the child within a developmental framework and as part of a family and social environment, it is essential that human service agencies concerned with his well-being collaborate with one another. From the child's earliest days there is a range of agencies concerned with his development. If there is poor coordination among these agencies, the help he needs will not be available when he needs it. He will be among the many who have "fallen through the cracks."

To prevent this from happening, human service agencies at all levels must pull together. As one of these agencies at the Federal level, NIMH should aggressively promote and encourage collaboration for the purpose of stimulating exchange of information, expansion and coordination of community services, initiation of preventive efforts, enrichment of training, and the increase and cross-fertilization of research.

The possible combinations for fruitful collaborative efforts are boundless. More active cooperation in child mental health programs should be sought between NIMH and other Federal agencies that have programs affecting very large numbers of children. Other components of the Health Services and Mental Health Administration, the National Institutes of Health, the Office of Education, Social and Rehabilitation Service, Department of Justice, Office of Child Development, Department of Housing and Urban Development, and the Office of Economic Opportunity are all potential partners for cooperative efforts. Collaboration on this level can be a powerful stimulus toward collaboration on other levels—State, local, private—to create, expand, and improve services for children.

The Service Agencies to Be Involved

Because of their impact on child mental health, the Committee believes that collaboration among the following human service agencies at all levels is particularly important:

A. *The Education System.* School personnel—administrators, principals, counselors, and classroom teachers—can be assisted to achieve a better understanding of their opportunities to promote the mental health of children by means of educational efforts, consultation, and the addition of mental health specialists to the school system. School personnel can also identify early states of emotional difficulties, refer children for evaluation or treatment (within the schools themselves as well as within the larger community), and provide continuing assistance to youngsters identified as having such difficulties.

B. *The Health Care System.* Infants and children—and their families—may need help from a wide range of health care personnel, including pediatricians

and other physicians, staff of pediatric and well-child clinics, public health nurses, hospital personnel in pediatric wards and emergency services, staff of institutions for chronically ill children, and school health personnel. The extent of understanding and sensitivity to children's and families' mental health needs among such personnel is highly variable. NIMH should support and strengthen mental health training for health personnel within professional schools as well as on the job. State and local mental health personnel can also play a key role in improving the capacity of these health workers to integrate mental health concepts and practices into their work with children and families.

C. *Social and Welfare Agencies.* Many children with a high risk of developing mental health problems are known to welfare and other social agencies. The staff of these agencies are in a unique position not only to identify early psychological difficulties but also to provide assistance. NIMH should encourage their collaboration with local mental health agencies for joint delivery of personal services, for consultation, for continuity of care, and for inservice training.

D. *The Justice System.* A high proportion of youngsters coming to the attention of the police, the juvenile courts, probation departments, and correctional agencies are already psychosocial casualties. Contact with the criminal justice system generally places them at increased risk to future trouble. Because the personnel of the law enforcement system are primarily concerned with the protection of society rather than with the needs of youngsters who have engaged in deviant, law-violating behavior, and of their families, other human service agencies must make a special effort to collaborate with the criminal justice system. Consultation to local police and related personnel, inservice training, and active collaboration regarding individual youthful offenders are logical starting points for cooperative efforts. Such efforts must also include attention to the many thousands of youngsters residing in juvenile correctional institutions.

E. *Day Care Agencies.* Pressure is growing across the Nation for a vast expansion of day care services for children. Well over four million working mothers have children under six, but less than 700,000 licensed day care spaces are available. The involvement of mental health workers, particularly at community levels, in organizing and strengthening local day care programs can assist these programs to contribute even more significantly to the growth and development of children. Consultation, loaning of staff, assistance in training programs, direct patient services for disturbed children, work with parents, and the ensuring of appropriate coordination with other child-serving agencies are major ways in which mental health agencies can strengthen the mental health potential of day care programs.

In all its work with child-serving agencies, the Committee believes the Institute should emphasize the importance of communication, cooperation, and collaboration with parents. Without such support parents may be discouraged from assuming responsibility and initiative in child care and education and their feelings of powerlessness and inadequacy may be increased. In the long run, professional care centered only on the child and not the family

will be unsatisfactory; for it will be episodic and divorced from an enduring, intimate, human relationship. Care centered on the whole family is care that fosters the continuing development of the individual within a supporting community.

Collaboration for Prevention

The need for collaboration is nowhere more apparent than in preventive efforts. The Committee believes that preventive programs in child mental health should receive more attention and a higher priority at all Institute levels than they have in the past. The ethical and economic arguments for devoting resources to prevention are well known and deserve to be honored more energetically. The usual reason for not undertaking preventive programs is that they are said to require social changes too complex and too vast to be feasible. As can be seen from the specific action proposals for prevention in Chapter II, this is frequently not the case. In many instances preventive goals can only be addressed through cooperative efforts. The Committee believes that the mental health professions must actively seek out and engage themselves with other human service systems. By combining resources and coordinating their efforts, the child-serving systems can win their way to many preventive goals that no one of them could hope to reach alone.

Child and Family Advocacy

One way to encourage inter-institutional collaboration in providing services to children and their families is through child and family advocacy programs. The Committee believes strongly that such programs at family, community, and State or regional levels could do much to overcome the continuing neglect of the mental health needs of children and that NIMH should assist in developing them. The knowledge of behavioral and social sciences possessed by Institute staff would be invaluable in this task. At the Federal level, NIMH should be an advocate for programs of child mental health within the Federal Government.

The need to develop information about child advocacy methods is discussed in Chapter III (Services), and the training of people to use the child advocacy approach, in Chapter IV (Manpower and Training). The child advocacy section of Chapter VI includes a recommendation that the Institute fund a small number of demonstration projects for child advocacy programs. The Committee recommends also that NIMH play an important consultative role to assist in developing advocacy systems.

Knowledge Development and Utilization

NIMH can contribute leadership in a very crucial area—the development, synthesis, and dissemination of knowledge about child mental health. Although NIMH may be loved by State and local agencies primarily for its money, it should strive to be a source of knowledge, imaginative programs, and wise counsel, as well as dollars. The basic direction for successful community child mental health programs, however, must come from the community itself, not the Federal Government. Further, not only must the programs be responsive to

the citizens, but citizens themselves must participate in determining their needs and setting goals for their community.

Knowledge development requires initiative by NIMH staff to support and conduct studies in basic and applied research and demonstration projects in priority fields that have been relatively neglected by investigators. The results of these studies and demonstration projects need to be evaluated and analyzed and then disseminated so that they will be of maximum use to persons developing child mental health treatment and preventive programs.

NIMH professionals are in a unique position to improve the utilization of research knowledge by turning to experts to sift, organize, and evaluate it. NIMH staff can then promote the utilization of this knowledge by providing technical assistance and by adding an advocacy dimension in their consultation activities to a wide range of program administrators throughout the country. In the long run such activities will prove to be among the most important the Institute can undertake.

The existence within NIMH of research, training, and service responsibilities creates unusual opportunities for the development of this communication function. In recent years the emphasis on grant administration, review of proposals, and technical assistance on specific applications has made more difficult and has tended to downgrade the importance of broad-ranging consultative activities that are not necessarily related to specific NIMH support mechanisms. Chapter VI contains specific suggestions for building a more effective program of knowledge development and dissemination.

The foundation on which is based not only programs of knowledge development but, indeed, all other aspects of the Institute's child mental health activities is research of high quality. The Committee emphasizes that child mental health is not a categorical research domain; it is a broad field including studies of the behavior and psychological development of children. Because widespread, large-scale, scientific study of children's behavior and development has been going on for only 15 to 20 years, there are still large gaps in our knowledge, and research results must usually be regarded as tentative. Chapter V points out that only 13 percent of the Institute's support of extramural research is directly related to child mental health. The Committee recommends a greater investment in child-related mental health research.

Sources of Funds for Research, Training, and Services

Expenditures for mental health research, training, and service delivery are made primarily by tax-supported agencies. About two-thirds of the public support of mental health services comes from the States and local governments, and one-third from the Federal Government. The NIMH accounts for only about six percent of the Federal funds available for mental health services. At the same time, NIMH supplies over 80 percent of the support of mental health research and training. Mental health services for children are funded through general mental health, health, or other human service systems, and there is no identifiable specialized Federal program of support for child mental health services. In general, this pattern is followed at State and local levels. (Although,

at these levels there may be specifically identified funds for mental health programs designed exclusively for children.) NIMH can exert leadership in the development of mental health services for children if it uses its dollars as an adjunct to a recognized position as a source of knowledge, imaginative programs, and wise counsel.

Implementation

As indicated in the preface, some of the ideas and recommendations of this report can be implemented with existing resources and manpower. For example, the Committee has recommended earmarking presently available funds for certain research and training activities related to children. In the long run, however, the Committee believes that greatly increased funding and manpower and new, imaginative programs will be required if a lasting improvement in the mental health of American children is to be effected.

The Institute must take care lest the implementation of the Committee's recommendations occur primarily in terms of rhetoric rather than by an actual shifting of NIMH staff and financial resources.

The Committee did not consider as part of its charge the weighing of alternative forms of overall NIMH organization for accomplishment of tasks. However, the Committee emphasizes that the decision to make the mental health of children the Institute's No. 1 priority will greatly change the activities of many staff members. They will have to change their priorities significantly and will have to alter their approaches to consultative work. Furthermore, the Institute Director, as well as key senior program managers, will have to develop mechanisms for continuously monitoring the extent to which the child mental health priority is being implemented.

NIMH should institutionalize a coordination-integration-advocacy *process,* independent of programs, which constantly monitors coordination to effect the basic recommendations of the Committee and assure and measure their implementation and achievements.

As an interim measure in the redirection of energy, the Committee recommends that the Director assign staff on a detail basis to assist in implementing recommendations in this report.

II. PREVENTION

General Principles

In recent years our understanding of the biological, psychological, social, and other factors involved in mental illness has considerably increased. Consequently, though much remains to be learned, our opportunities to prevent mental illness have also increased. The Committee recommends that all levels of the Institute give more attention and higher priority to preventive programs and ideas.

Where large-scale social changes are required to accomplish preventive goals, the Committee recommends that the Institute combine its resources and coordinate its efforts with other Federal agencies by means of intensive collaborative activities. It particularly recommends that the Institute establish extensive collaboration with the Federal agencies affecting the schools, the health system, and the legal system.

Preventive programs should give high priority to the child aged 0 to 6 and to adolescents aged 13 to 20. The child from 0 to 6 is laying the foundations for all of his future development. Adolescents deserve special attention because they experience a very high level of stress and have a high incidence of serious problems such as drug abuse, alienation, and suicide. Both groups can be reached not only through Institute programs but also through a variety of other Federal programs, with which the Institute should collaborate.

The Committee recommends that all treatment, training, and research programs, whether concerned with prevention or not, view children as developing individuals who are influenced by social, cultural, and physical environmental factors. The family, as a very important channel for these influences, should be a particular focus of child mental health programs. Mental health programs that strengthen and support family care of children, rather than those that supplant it, should be emphasized. Children without families must be given a great deal of attention since they run a higher than average risk of developing mental health problems.

Seven Areas for Preventive Work

The Committee's proposals for expanding the Institute's preventive programs fall into these categories: family care of children, day care of children, the school system, measures relating to young people—in particular youth involvement in NIMH activities, the health system, the legal system, and the community mental health centers. The recommendations are set forth in the following sections.

A. *Family Care of Children.* Since the family has the major responsibility for child care and is the major influence upon child development, *the Committee recommends that the Institute:*

1. Support demonstration projects to help parents and future parents obtain a better understanding of the psychosocial aspects of normal and abnormal child development. This should be a collaborative effort by the Office of Communications, the Division of Manpower and Training Programs, and the Center for Studies of Child and Family Mental Health. It should also involve the Office of Education, the Office of Child Development, and the Office of Economic Opportunity.

Educational efforts should be directed at providing parents and future parents not only with an understanding of child development but also with appropriate methods for coping with child-rearing tasks. Included should be programs for training boys and girls for future parenthood through both course work (in the schools and other institutions), and supervised experience in child care.

Examples of possible NIMH efforts to this end include: production of special TV programs dealing with child mental health issues (these could be modeled after *Sesame Street,* or consist of short "spots," or be in the nature of TV specials similar to *The Distant Drummer* series); preparation of books, manuals, films, and pamphlets to be used for specific educational purposes or for mass distribution; and demonstration programs organized by community mental health centers or other agencies to conduct mental health education programs for parents.

2. Develop training, consultation, and counseling programs designed to strengthen and support family care—programs that develop skills, provide social supports, and reduce stresses affecting family functioning.

3. Develop training methods that will shift the current emphasis of professions and institutions from child-centered to family-centered approaches to prevention and treatment.

4. Collaborate through the Continuing Education Branch with other Federal agencies in developing family planning material for family life education courses in high school and college.

B. *Day Care of Children.* The Institute should work to influence day care programs in a number of ways. *The Committee recommends that the Institute:*

1. Evaluate existing models of mental health input into day care programs and develop improvements in these models.

2. Promote mental health input into day care programs through collaboration with the Office of Education, Office of Economic Opportunity, Social and Rehabilitation Service, and the Office of Child Development.

3. Ensure that standards set at Federal and State levels for day care programs include mental health considerations.

4. Develop mental health materials for the training of day care workers and those responsible for licensing day care centers.

5. Collaborate with the Department of Labor on projects to train men and women for work in day care programs.

C. *The School System.* Opportunities for promoting mental health and preventing mental illness exist at every level of the school system from

summer workshops for children and their parents can provide information regarding the strengths and problems of the child, and this can be used by the parents and teachers, working together, to help the child adapt to the school environment. At all school levels, inservice training programs for school principals, administrators, and teachers can help reduce inappropriate stresses, promote supportive reactions to developmental tasks and to crises in children's lives (such as moving and the sickness or death of a parent), and help identify youngsters who are likely to become school drop-outs, so that preventive actions can be taken.

The Committee recommends that the Institute:

1. Collaborate with the teacher-training division of the Office of Education to introduce into teacher-training programs information on child development and mental health principles in the classroom.

2. Collaborate with State and local boards of education in sponsoring national, regional, and local conferences to convey "state of the art" information about child development and school-related mental health principles to teachers and school administrators.

3. Fund (jointly with the Office of Education) certain demonstration programs or projects—for example, projects designed to prevent learning disabilities.

4. Use its research grant mechanism to produce information on how the schools can work for the prevention of learning disorders, alienation, racism, and violence.

5. At the college level, identify successful models of college mental health programs and disseminate them to the field.

D. *Measures Relating to Young People.* One of the many causes of unrest, alienation, and dissatisfaction in today's youth is the paucity of opportunities to participate in the power structure of our society, particularly of the institutions affecting young people. As part of its efforts to promote mental health and prevent mental illness, the Institute should involve more young people in its programs—should create more opportunities for people of high school, college, and somewhat older ages to participate in Institute activities.

To this end the Committee recommends that the Institute:

1. Place persons under 30 on a number of NIMH Review Committees—for example, those in the Division of Narcotic Addiction and Drug Abuse and the Psychiatry, Psychology, and Social Work Review Committees in the Division of Manpower and Training Programs.

2. Create more summer job opportunities for youths in NIMH programs.

3. Convene ad hoc youth advisory councils for NIMH divisions planning or carrying out programs directed at young people, such as programs of drug abuse education.

4. Encourage research projects that focus on youth to use, insofar as possible, some of the staffing monies for youth employees.

In addition to involving youth in its activities, *the Committee recommends that the Institute:*

5. Support an expanded research program on the factors contributing to adolescent turmoil. More information is needed in this area to design effective preventive programs.

6. Support expanded public information and education programs, especially utilizing the mass media, to present to youth the facts about such pressing social problems as drug abuse, suicide, etc.

7. Give serious consideration to promoting interest in the behavioral sciences through a system of awards for high school and college youths.

E. *The Health System.* The Institute can work with the health system to develop preventive programs in a number of areas, of which the most important are probably family planning and pre- and postnatal care.

1. Family planning can have an important effect on the mental health of the child and the family. It reduces the number of unwanted children, who are more likely to be the disturbed, alienated, and violent youths and adults of tomorrow.

The Committee recommends that the Institute:

a. Collaborate with the National Center for Family Planning Services in HSMHA for the dissemination of family planning materials in psychologically effective ways;

b. Sponsor research on effective means of disseminating family planning information.

2. Good pre- and postnatal care equals prevention. But it is not available to many women and is sometimes resisted when it is available. *The Committee recommends that the Institute:*

a. Collaborate with the Maternal and Infant Care Program of HSMHA in disseminating—through community mental health centers, for example, and the family life education courses previously recommended —what is already known about providing good pre- and postnatal care;

b. Develop educational materials for prospective and new mothers which discuss the emotional reactions of women in the postnatal period and teach techniques of caring for their new infants.

3. Other steps can be taken. One relates to hospitalization for physical illness, which is often traumatic for children. *The Committee recommends that the Institute:* Sponsor workshops that teach hospital administrators, pediatricians, and pediatric nurses to provide emotional support for hospitalized children and to keep to a minimum the time of separation from parents. The Institute should also consider using other means to the same end, including preparation of materials for training health workers and widespread dissemination of the book, *Red is the Color of Hurting.*

F. *The Legal System.* At every level of government, the Institute needs to increase its activities to prevent juvenile delinquency and crime and to rehabilitate offenders. At the Federal level, the current collaboration with the Department of Justice's Law Enforcement Assistance Administration with regard to alcoholism and drug abuse is an excellent beginning.

The Committee recommends that the Institute:

1. Broaden its collaborative activities with the Department of Justice to include wider and more effective use of means to: prevent recidivism in first offenders; ensure that emotionally disturbed individuals are not inappropriately referred to or retained within the judicial system; and provide mental health services to inmates of institutions.

2. Consider joint funding of research projects on the prevention of delinquency with the LEAA National Institute of Law Enforcement and Criminal Justice.

3. At the regional and State level, work to disseminate information—through conferences, workshops, printed materials—on the prevention of delinquency and the treatment of delinquents to officials of the educational, judicial, and penal systems.

G. *Community Mental Health Centers.* A unique and powerful means of putting preventive principles directly to work in all areas of mental health is offered by community mental health centers. *The Committee recommends that the Institute:* through consultation with center officials and staff and through priority rankings on initial and continuation grants—encourage community mental health centers to work in all the areas discussed above to develop preventive programs. It should encourage them, for example, to strengthen family resources for caring for children, promote quality day care programs for young children, increase the centers' consultation with the schools, work to provide training and job opportunities for youths, both within the centers and elsewhere, and consult with the health and legal systems to promote preventive programs.

This subject is considered at greater length in the next chapter.

For Administrative Action

With regard to administrative matters, *The Committee has three recommendations:*

1. The Institute should quickly broaden its collaborative activities with Federal agencies affecting the schools, the health system, and the legal system.

2. The Institute should markedly increase its efforts to disseminate important research results, training models, and treatment models. For much is already known that, if applied, would enhance the health, growth, and development of children. Institute staff and money should be diverted from other activities and devoted to this process of disseminating information and stimulating its use.

3. One or more staff members should become advocates within NIMH, with the assigned full-time responsibility of ensuring that programs with primary prevention effects are given increased attention throughout the Institute.

III. SERVICES

The Committee's recommendations to improve and expand direct service programs for children relate to all of the Institute's direct service support programs. Although more detailed study was given the Community Mental Health Centers, Hospital Improvement, and demonstration and exploration project grant programs, the Committee's expressed philosophy and recommendations also apply to the service support activities of the Center for Studies of Child and Family Mental Health, Mental Health Study Center, Center for Studies of Suicide Prevention, Center for Studies of Crime and Delinquency, Division of Narcotic Addiction and Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism.

Community Mental Health Centers Program

This program represents the Institute's major current commitment to direct support of the development of community-based mental health delivery systems and comprises a significant portion of the Institute's budget. As of June 30, 1970, 420 community mental health centers were funded for catchment areas having a total population of 57 million persons. This is 28 percent of the total U. S. population. It includes 19 million children and adolescents under age 18.

All community mental health centers are required to serve the mental health needs of children residing in their catchment areas, but the extent of development of children's programs varies widely.

During 1969, children comprised more than 20 percent of all persons admitted to reporting centers for direct treatment (52,278 first admissions under age 18, compared with 254,852 total first admissions). Children benefited by direct treatment services to parents and families are not included in these figures.

Ninety-eight percent of all community mental health centers provide consultation services to schools.

About 250 of the 420 funded community mental health centers have planned some type of specialized service for children.

Despite the limitations on program growth in the near future, it is both feasible and important to give higher priority, with present resources, to the organization and development of children's mental health services within the Community Mental Health Centers Program. The Division of Mental Health Service Programs has already initiated action toward this end.

The Committee recommends that the Institute:

1. In the review, approval, and monitoring of both new and continuation grant applications, require centers to implement fully the provision of at least essential age-appropriate services for children and adolescents.

2. Use regional and central office developmental consultation for community mental health centers grants to stimulate services to children. Use site visits and follow-up consultation to encourage continued attention to the needs of children.

3. To the extent possible within the existing legal and regulatory framework, give preference to those construction and staffing applications that reflect more equitable and adequate programs for children and adolescents.

4. Review laws, regulations, and policy statements with regard to their adequacy for giving higher priority to comprehensive, high quality child mental health programing. Give special attention to the current fund allocation process among States, to the possibility of reserving funds for children's services, to State planning requirements, and to provisions for multi- and sub-catchment area programing of children's services.

5. Urge community mental health centers to give priority to activities having primary and secondary preventive implications. Point out that special attention to collaboration with other human service agencies will not only improve the planning, organization, and delivery of children's services but also provide opportunities for the centers to influence programs vitally affecting children. Urge centers to:

a. Emphasize prevention in their consultation and collaboration with the school, health, and legal systems and with day care programs;

b. Give high priority to preventing institutionalization–in mental hospitals, juvenile halls, jails–and voluntary or forced drop-out from normal child-life patterns;

c. Give high priority also to outreach activities–both preventive and treatment–directed at the preschool child, very young and unsophisticated parents, and disturbed families;

d. Be alert to the opportunities for involving young people in the centers' work.

Additional resources would allow greater attention to the needs of children. *The Committee recommends* they be requested through:

1. Authority and funds to implement the child mental health provisions of the 1970 Amendments to the Community Mental Health Centers Act, and

2. Additional funds to enable more rapid implementation of children's services through the basic Community Mental Health Centers Program.

As the specialized Community Mental Health Centers Act resources in the areas of alcoholism and drug addiction and abuse become available, the applicability of these recommendations should be studied.

Hospital Improvement Project Grant Programs

This program aims at improving patient care in State mental hospitals, with the goals of reducing the incidence and length of hospitalization and of eliminating custodial care. The budget is limited but important. Similarly the size of the target population, children in State hospitals, is relatively small but

growing; it is particularly significant in terms of human needs and lifetime costs. Higher priority to child mental health services within the Hospital Improvement Program (HIP) can be given, with present resources, through several techniques.

The Committee recommends that the Institute:

1. Establish a priority that will encourage submission of applications focused on children's programs from those State hospitals where there are large and growing children's populations and where the community and State are ready to take action beyond that supported by the HIP grant.

2. Establish guidelines for reviewing applications that necessitate: clear demonstration of need, as judged by the institution, the community, and the State; and adequate programing both within the institution and between the institution and the community to help develop community-based programs for children that reduce the number of children institutionalized and shorten the length of institutionalization.

3. Use Institute staff, HIP Review Committee members, and consultants to review residential service programs in both State hospitals and communities. The review should identify programs that have demonstrated effectiveness in reducing institutionalization. The findings should be publicized throughout the mental health field.

Demonstration Projects Grants Programing

Knowledge about systems of community-based child mental health services is poorly organized and, indeed, often lacking. Specific information on the needs of different kinds of communities and on the methods that work best in each kind is not available. There is a vital need for a continuing program to determine and evaluate the state of the art of community-based children's mental health systems. For example, many different innovations in service are known to be under trial. Since they are not being systematically evaluated, however, whatever demonstration value they have may be lost. The required studies, demonstrations, and evaluations can be undertaken in large part through use of existing project grant authority and funds.

The Committee recommends that the Institute:

1. Undertake a continuing program to assess and develop the state of the art of community-based child mental health services. The program should include:

   a. Identification and testing of existing innovative efforts that hold promise for model development;

   b. Initiation and testing of additional innovative efforts;

   c. Evaluation and synthesis of results and communication to the mental health field.

2. Draw all its service program resources into the recommended program—Center for Studies of Child and Family Mental Health, Division of Mental Health Service Programs (including the Mental Health Study Center), Center for Studies of Suicide Prevention, Center for Studies of Crime and Delinquency, Division of Narcotic Addiction and Drug Abuse, and the new National Institute on Alcohol Abuse and Alcoholism.

resources for:

a. The required studies, demonstrations, explorations, and evaluations;

b. Selective, direct support for the initiation of services, through the funding of demonstrations chosen on the basis of critical local need.

4. Request increased funds for support of local level demonstrations.

5. Give priority to knowledge development in the following areas:

a. Methods for developing and exercising advocacy functions, both within existing programs such as community mental health centers, school systems, and other human service agencies, and in programs independent of existing agencies. A wide range of methods should be tested. For example, methods of exercising advocacy functions within mental health centers might include at one end the development of a specialized advocacy service and at the other end the designation of one staff member as the advocate with coordination and liaison responsibilities within the center's program and with respect to other human service programs.

b. Developmental, preventive, and treatment implications of children's day-care centers. Studies should include the content of the program, kinds and functions of personnel, staff-child interactions, parent-child-staff interactions, and the effects of the program on family roles, educational development, personality development, and mental health.

c. Community-based programing activities that serve as alternatives to community mental health centers and as alternatives to institutionalization in State mental hospitals or traditional correctional facilities. Models consistent with the basic concepts and goals of the Community Mental Health Centers Program should be identified. Among the services to be explored are residential treatment centers, group homes, foster care, boarding homes and schools, halfway houses, day care, special schools and classrooms, nursery schools for emotionally disturbed children, big brother and big sister programs, general hospital services, outpatient services, and combinations of these in a framework of community planning and system development.

d. Effective ways to involve youth as staff, consultants, advisors, advocates, and volunteers in the planning and delivery of mental health services for children. Particular emphasis might be placed on involving young adults in preventive and treatment programing in such areas as alcoholism, drug abuse, and delinquency, and involving adolescents in working with other adolescents and younger children.

e. Effective ways for community mental health services to work with other human services toward carrying out preventive and treatment activities. Examples of important areas which should be studied are:

(1) Preventive and treatment programs within the school system. These include crisis intervention, referral, nursery schools for

emotionally disturbed children, consultation to school administrators and to teachers, and courses in mental health principles for teachers.

(2) Collaboration between the mental health and juvenile justice systems. This includes studying ways in which problems manifested by children and youth can better be handled through mental health and other social agencies than through the juvenile justice systems.

IV. MANPOWER AND TRAINING

A major barrier to expanding and improving preventive and treatment programs for children is the scarcity of personnel in mental health and other fields who are adequately trained for work in this area. Programs that focus on issues in child mental health are rarely found in the major training institutions. Where they do exist they generally are isolated from other mental health training efforts and are narrow in their emphases. For example, child psychiatry training is usually restricted to a very small proportion of all residents receiving training in a particular department. As a result, the vast majority of psychiatric residents do not feel qualified to work with children. Further, few prospective mental health personnel receive any training in working with such child-serving and family-serving agencies as general hospitals, health departments, juvenile courts, social and welfare agencies, and day care centers.

General Principles

If NIMH is to implement its high priority for child mental health programing, it must make significant modifications in support of mental health training activities.

As governing principles for NIMH training activities in the area of child mental health, *the Committee recommends that the Institute:*

1. Increase the capacity of training institutions (psychiatry departments, schools of social work, etc.) to provide training for mental health professional and paraprofessional personnel which focuses specifically on children's needs. In this way the Institute's limited fiscal resources will have their greatest impact.

   Such child-focused training for mental health personnel in many instances will require the departments and schools to modify significantly their existing training programs. Priority should be given to training personnel for the delivery of comprehensive community-based treatment and preventive services. Other key elements in training programs include: collaboration and consultation with human services agencies, utilization of a wide range of therapeutic and preventive methods, tailoring of services to needs of particular sub-groups of children, and emphasizing importance of community participation in the development and control of such services.

2. Place more emphasis on the training of professional and paraprofessional workers in child-serving fields other than mental health. In the past, NIMH training funds have been used primarily to train mental health personnel, but it is clear that key roles in treatment as well as in prevention can be played also by nonpsychiatric physicians, other health personnel, social and welfare workers, criminal justice personnel, and others. The

Institute should help train them in the principles and practices of child mental health.

3. Jointly plan and execute training efforts with other NIMH efforts in this area—for example, in child advocacy, day care, demonstration programs, prevention. Only through coordination can Institute child mental health activities have the maximum impact and enable the Institute to provide national leadership.

4. Use its influence, in all Institute-supported training programs, to promote the development of family-centered and community-centered approaches to child mental health. Since parents have the major responsibility for child development and are the major influence upon it, workers and institutions in the field of child mental health should have a primary goal of supporting and strengthening family care, a secondary goal of supplementing it when necessary. Training should be for family-centered rather than child-centered services.

Not only extramural but also intramural training efforts, such as those of the Vestermark Division of Intramural Training and of the Mental Health Study Center, need to be placed fully in line with the No. 1 priority for child mental health.

Training of Mental Health Personnel

The men and women now being trained will be leaders in the mental health programs of the future—in many cases, the very near future.

The Committee recommends that the Institute:

1. Give highest priority to efforts directed at strengthening the child mental health component in the basic psychiatry residency, M.S.W. social work, Ph. D. psychology, and psychiatric nursing training programs it supports. These programs should emphasize the learning experiences that will best equip young mental health professionals to participate in programs of comprehensive community treatment and preventive services for children.

2. Give preference, in awarding new and renewal grants, to projects that provide broad training in the child mental health areas. One means whereby NIMH can give national leadership in this regard is through the organization and support of workshops and conferences for key teaching staff of major training institutions.

3. Expand training programs for new types of child-related mental health specialists, such as "child-care workers," "child development counselors," and "child development specialists." These programs can be at the master's, bachelor's, or nondegree level. A sizeable proportion of the Institute's resources for "new career" training should go to programs that develop competence in the child mental health field.

4. In considering training programs in the psychological, social, and biological sciences, give preference to the training of investigators who will be particularly qualified to study problems related to child mental health.

5. Work to make the understanding of child mental health problems and interventive methods a central component of continuing education and inservice training programs supported by NIMH. Special workshops and conferences can be used to educate the staff of such programs. Particularly lacking in the basic educational experiences of most mental health professionals is specific training to prepare them for consultative work with major child-serving agencies such as the schools, the courts, day care centers, and health departments. Continuing education for mental health staff must include this essential activity.

Training of Child-Serving Personnel

Few physicians, nurses, welfare workers, policemen, juvenile judges, parole officers, clergymen, or lawyers are qualified to function effectively in relation to community treatment and preventive child mental health programs. Yet such personnel are in crucial positions to engage in early case-finding activities, make referrals, provide supportive and counseling services, and, perhaps most importantly, participate in programs aimed at fostering the wholesome psychosocial development of children. In the absence of active participation by these child-serving personnel it will be difficult, if not impossible, to develop effective mental health programs for children.

The Committee recommends that the Institute:

1. Influence to the fullest extent possible the educational institutions that provide the basic professional training of child-serving personnel. The Institute should:

   a. Help arrange and sponsor workshops, institutes, and seminars for the faculty of these institutions;

   b. In selected instances, provide financial support to enable these institutions to develop and strengthen their teaching activities related to child mental health.

   c. Support the preparation of specialized teaching materials—manuals, case studies, etc.—that the institutions can use.

2. Work to expand training opportunities for staff of hospitals, health and police departments, juvenile courts and probation departments, schools, child welfare agencies, day care centers, recreational agencies, and so on. Principally, the Institute should identify the agencies able to undertake training programs themselves and work to strengthen their readiness and capacity to do so. The agencies include regional educational associations, community mental health centers, extension divisions, State mental health departments, and community colleges. NIMH should help support both workshops and conferences for the staff of such agencies and the preparation of specialized training materials.

Training for Preventive Work in the Schools

The training of school personnel needs particular attention because they can significantly influence the psychological development of children.

The Committee recommends that the Institute:

1. Take the lead, in collaboration with the Office of Education, in strengthening mental health components in teacher and school administrator training programs, including workshops and institutes for the faculty of such programs.

2. Develop and assist in the funding—again in collaboration with the Office of Education—of inservice workshops, conferences, and the like to provide extensive short-term training for currently employed school personnel.

3. Develop, through contract, an educational do-it-yourself package for use by State and local groups for the inservice training of teachers, principals, and administrators.

4. Set aside at least $750,000 in fiscal year 1972 specifically for the support of training programs related to preventive work in the schools.

Training in Relation to Day Care Programs

Day care programs, which will vastly expand in coming years, offer unusual opportunities to promote preventive, early case-finding, and interventive activities.

The Committee recommends that the Institute:

1. Help develop short-term training for State personnel involved in the licensing and inspection of day care centers. Emphasize the need for standards concerned with the staff and the program as well as those concerned with health and with physical facilities.

2. Help organize and support national, regional, State, and metropolitan area training workshops and institutes for mental health personnel in a position to provide consultation to day care programs. Few if any mental health professionals have had any experience in providing such consultation.

3. Influence the training of day care personnel by stimulating and supporting those agencies and educational institutions able to organize continuing short-term courses and workshops for such personnel. Actions here include:

   a. Training people to take a leadership role in organizing and conducting these courses and workshops;

   b. Supporting efforts to develop do-it-yourself packages for the education of day care personnel, to be used by State and local agencies, extension divisions, and community colleges.

Child Advocacy Training

Because the advocacy approach to meeting children's needs is relatively new—see Child Advocacy Programs in Chapter VI—few people have been trained to use it. The Institute's short-term priority should be for programs of continuing education and inservice training for personnel soon to assume child advocacy roles. In the long run, however, attention to child advocacy concepts in the basic training of mental health and other child-serving professionals will be of greater importance.

The Committee recommends that the Institute:

1. In all its proposed demonstration child advocacy grants, include funds for appropriate training activities for professional and paraprofessional personnel. Priority should go to the training of persons already hired or about to be hired by advocacy programs. Both clinical (direct service) and community (organizational change agent) types of advocates should be included. NIMH funds should be used to support:

a. Development of teaching materials and curricula for child advocacy training;

b. Continuing education and inservice training programs in child advocacy organized by mental health centers, universities, community colleges, and so on;

c. National, regional, State, and local training programs;

d. Development of do-it-yourself training packages for use by various groups.

2. Assign the development of the training aspects of NIMH-supported child advocacy programs jointly to the Center for Studies of Child and Family Mental Health, the Division of Mental Health Service Programs, and the Division of Manpower and Training Programs. Have the combined service-demonstration and training grant applications reviewed by an ad hoc committee selected by staff of the three NIMH programs most directly concerned.

3. Work to increase the ability of both professional and "new career" workers in community mental health centers to function effectively as child advocates. Training activities should consist primarily of workshops, seminars, and institutes organized on national, regional, State, or community bases. NIMH should assist in the development, funding, and preparation of teaching materials and curricula for such short-term training efforts.

4. Use its influence to have child advocacy approaches and methods emphasized both in the basic training of professional and paraprofessional workers in mental health and other child- and family-serving fields and in continuing education and inservice training programs. NIMH can assist by supporting workshops and institutes for the faculty of these training programs, providing supplemental funds to programs particularly emphasizing child advocacy training, and by preparing curricula, manuals, and case studies for use in professional training schools and departments.

5. Support workshops and institutes to increase the readiness of people already working in child-serving capacities—as doctors, public health nurses, teachers, lawyers, policemen, clergymen, social and welfare workers—to include child mental health advocacy among their activities. The objective is not to train specialists in child advocacy but to familiarize people with the child advocacy approach and make them more aware of their opportunities to use it.

Implementing the Recommendations

To achieve the proposed training objectives, *the Committee recommends that the Institute:*

1. Stress in a variety of ways the priority being given to child mental health in its training activities. Besides communicating this priority through public statements, speeches, and guidelines for applicants, the Institute should:

a. Stress this priority in all its consultative and development work;

b. Discuss it with Training Review Committees, and make interest in the child area a key consideration in selecting new committee members;

c. Give preference in the funding of approved renewal and new applications to those directly related to child mental health.

2. Announce the establishment of new training programs, such as those proposed in Training for Preventive Work in the Schools, page 20. It should assign staff to work on these programs and to process applications, and it should establish new, interdisciplinary committees to review the grant proposals. The Institute should allocate specific funds to each program for each fiscal year. Announcements of programs should specify the type of training activity to be supported, the people eligible, the duration and maximum amount of awards, and so on.

3. Set aside specific funds each year for child-related training projects. The Committee recommends that annually, at least over the next few years, the Institute set aside 50 percent of "free money"—funds available for new projects and for competing renewals—for projects directly related to child mental health training. During each of the fiscal years 1972 and 1973, the Committee recommends that at least $4,000,000 be earmarked for this purpose.

V. RESEARCH ON CHILD MENTAL HEALTH

Research is the soundest way to arrive at an understanding of the nature of human development and behavior. It is the underpinning of efforts to serve the mental health needs of children. The Committee's deliberations focused primarily on the questions:

1. In the context of an Institute priority on child mental health, what are the research needs?
2. How best can research serve the needs of society—in the sense both of relieving immediate stresses and ills and of making long-term contributions to human welfare?
3. How best can relevant research be fostered?

To answer these questions, the Committee first made a progression of analyses dealing with the domain of child mental health research, the origins of our present knowledge, child mental health research in current NIMH programs, the practices of research, and the areas to which research has given attention. The Committee then drew up recommendations for the NIMH research program that can be implemented in the coming year.

The Domain: Child Mental Health

Child mental health is not a categorical research domain. It is, rather, a broad grouping of studies devoted to the psychological development of children and the factors influencing their development and behavior. The relevant realms of study encompass the normal and abnormal in behavior, the biological substrata of behavior, and environmental factors—including not only the interpersonal relationships but also the broader social matrices in which development takes place.

A Historical Perspective of Child Mental Health Research

The body of basic knowledge currently available relating to child development and behavior is seriously incomplete. Most of its findings, and certainly the interpretations and generalizations drawn from those findings, must be viewed as subject to change. As new tools of inquiry and additional information come to light, research conclusions must be subjected to requestioning and re-examination. It is well to remind ourselves that treatment and services in the field of mental health are often based on limited knowledge and untested assumptions.

The scientific study of child behavior has a very short history. The period 1925 to 1945—primarily a period of descriptive, normative study—saw the beginnings in American research. Only in the last 25 years, and particularly the last 15 years, has there been a strong research movement into child development, personality, and behavior. Only in this period have theories, experimentation, intervention procedures, and interdisciplinary work grown into a recognizable entity that can be identified as child mental health research.

This fact alone should signal a warning about the amount of fundamental knowledge available at the present time and about the amount of sifting and integrating of the knowledge that has taken place.

In viewing future research directions, a further historical perspective is essential: Children as subjects were sometimes important to the research question being pursued but more often not. Many of the advances in understanding human processes and human behavior, and many of the intervention and treatment approaches to the behavioral and emotional disorders in children grew out of research that was not in any way conceptualized or directed toward children or mental health problems.

Much, if not most, mental health research of the past few decades has been investigator-initiated. Freedom of inquiry on the part of scholars has produced an impressive body of information and theory in the mental health field. Insufficient though it is, this knowledge has been of direct service to human well-being; for example, basic endeavors in such areas as learning, cognition, and brain functioning have resulted in very practical yields, such as understanding learning disabilities, behavioral modification techniques, origins of specific behavior problems.

In the short history of growth in the behavioral sciences, NIMH has had an influential role.

Current NIMH Support of Research in Child Mental Health

Research relevant to child mental health is supported in the biological and behavioral sciences by both the extramural and intramural programs of the Institute. Extramural research is to a large extent investigator-initiated, but staff members do attempt to stimulate interest in various research areas. The colleague-expert review system of Study Sections is the basic screening procedure for selecting among competing grant applications in the extramural programs. In the intramural program, too, research is mainly an investigator-initiated process, with colleague review; selective recruitment sustains and supplements existing research program interests. Institute research is not organized around children as a domain separated from research on human development and behavior.

Since child mental health is not a precisely defined field and since investigations of many different subjects are relevant to child mental health, there are likely to be ambiguities in the tagging of projects as falling within this area. However, a scanning of 276 current project summary reports containing the words "child-children" or "adolescent-adolescence" yielded 178 reporting on research judged to be primarily related to child mental health, 62 secondarily related to child mental health, and 36 of peripheral relevance. A breakdown by broad research subject category of the 178 research projects of primary relevance is in *Table I* (page 26).

As of June 30, 1970 the intramural program included 46 research projects of relevance to child mental health. One third of the professional man-years of the intramural program are devoted to child mental health research.

Table I

EXTRAMURAL SUPPORT OF CHILD MENTAL HEALTH RESEARCH

Diagnosis, Etiology and Psychopathology (38 projects)	$ 2,735,628	26.71%
Treatment and Services (47 projects)	4,047,812	39.53%
Biological and Physiological Correlates of Behavior (6 projects)	200,259	1.96%
Social and Cultural Correlates of Behavior (35 projects)	1,528,429	14.93%
Psychological Aspects of Behavior (51 projects)	1,694,768	16.55%
Special Categories (1 project)	32,284	0.32%
	$10,239,180	100.00%
Total NIMH Extramural Research Support (approx.) FY 1970	$77,754,000	
Primary Child Mental Health Support / Total NIMH Extramural Research Support	$10,239,180 / $77,754,000 =	13.17%
Child Mental Health (Secondary Interest) Support	$ 3,996,330	
Primary and Secondary Child Mental Health Support / Total NIMH Extramural Research Support	$14,235,510 / $77.754.000 =	18.31%

Recommendations for NIMH Research Policies

The Committee's proposals cover four fields: the Institute's policy as to research, the quality and utilization of research, the subjects to be given priority in research, and actions to be taken to implement the research priorities. The proposals deal mainly with research in the behavioral sciences. Service-related research is dicussed in Chapter III (Services)

A. *Research Philosophy.* Research endeavors in all scientific disciplines demonstrate that a strong *basic* research program is the foundation of knowledge and therefore of the application of knowledge. Research that has proved to be fundamental to the solution of social problems has only on rare occasions been initially and specifically addressed to those problems. Reasons for this are well known but often overlooked. One of these is the fact that the most important contribution that the research investigator can make is in the formulation of the problem. It is through his ability to formulate practical

problems in terms of scientific concepts and principles that he brings accumulated research knowledge to the solution of specific problems. No phase of research gets anywhere if it builds on an erroneous formulation.

Knowledge tends to be achieved slowly and unpredictably out of the inspiration and energies of many investigators. "Breakthroughs" rarely occur. What seems to the nonexpert to be a momentous, unheralded discovery is most often a small piece of knowledge that builds into many preceding, interlocking pieces after many discards and false tries.

The Committee recommends that the Institute:

1. Commit itself to basic research relating to child mental health and to the encouragement of the highest quality of basic, cumulative research. Instead of segregating research about children from the major currents of endeavor in the behavioral sciences, the Committee urges that the Institute use its finances and prestige to encourage institutional and individual arrangements that foster intellectual interchange among investigators whose work centers on children and those whose work centers on other research endeavors—all of which conceivably bear upon children.

2. Commit itself also to utilizing the findings of basic research for research aimed at improving methods of prevention and treatment.

B. *Research Quality and Utilization.* A critical review of the field clearly indicates that, within present levels of research support, more effective research could be done and that the research presently being done could be more effectively utilized. It is within the power of NIMH to facilitate these improvements.

In the following sections, the Committee points to some characteristics of current research practices that result in a number of shortcomings, and offers recommendations.

1. There is an overemphasis on data-collection, an underemphasis on the analysis and interpretation of collected data, and an underemphasis on the synthesis of findings.

The Committee recommends that the Institute encourage syntheses of existing knowledge and support individual investigators to make thoroughgoing assessments of facts and theories relating to important child mental health issues. Two types of synthesis are needed: syntheses to further the conceptual development of the relevant academic disciplines and syntheses to aid in assessing the implications of research for program planning.

By identifying existing knowledge in specific areas as well as uncertainties and gaps in knowledge, such integrative analyses could do much to further cumulative research. For example, critical evaluation of evidence regarding the long-term effects of early experiences, and the reversibility or irreversibility of such effects, is needed. Particularly, what is the evidence of the effects of early experiences other than severe deprivation or trauma—that is, the effects of variations in the "normal" realms of experience? The Committee is also impressed with the desirability of encouraging critical assessments of the research evidence underlying those theories being used as the basis for major action programs.

2. The time-frame within which data are collected is often too short, for funding tends to be for short periods. This can pose a serious problem for much research in the behavioral sciences where the questions are those of developmental processes, etiology, change, prognosis, effects of intervention, etc. In such studies, data-collection ought to be done over appropriate spans of time. The problem with respect to longitudinal studies is especially acute. Not all research on children need be longitudinal, or longitudinal in a life-span sense, but clearly some significant efforts on well-planned longitudinal studies are needed.

The Committee recommends that the Institute make specific provisions for the planning and funding of short- and long-term longitudinal research.

3. A large proportion of research relating to children has serious limitations with regard to the generalizability of its findings. For example, findings from studies of developmental processes, child-rearing practices, and behavioral disorders in middle-class, white, urban families have been interpreted as if they were prototypic of mankind. This is partly a problem of sampling, partly a problem of conceptualization. Research in child mental health must be planned and evaluated not only in terms of the sophistication of statistical procedures and experimental design but also in terms of the recognition shown that developmental processes may differ greatly in different segments of society and in different cultures.

The Committee recommends that the Institute place greater emphasis on comparative studies—comparisons of the various class and racial segments of American society and cross-national comparisons. In this way it will learn what is true only in the context of particular subjects, times, and circumstances and what is more generally true. In particular the Institute should reinvigorate its program of cross-national research. For such research, when planned to be comparative, offers an unmatched opportunity for assessing how far one can generalize from American studies.

4. Certain types of research do not lend themselves to exploration by an individual. The investigation of important research areas can be hindered by limitations in perspectives, facilities, populations, locations, and funds at the disposal of a single investigator or single research team.

The Committee recommends that the Institute foster continuing communication and collaboration among individual investigators working in common interest areas. Collaborations would strengthen research by making use of more substantial samples, by replicating procedures and findings, and by pursuing research programmatically through interlocking efforts.

Rather than large-scale collaborations, the Committee suggests collaboration among scientifically congenial investigators, in different locations, pursuing research from different vantage points. Such collaborations could respond more flexibly to research opportunities and requirements. They could be easily created, dissolved, or changed, as dictated by research needs.

5. There has tended to be less than adequate communication among different segments of the mental health field: investigators engaged in basic research, those engaged in applied research, and consumers of research—

program planners, the practicing professions, and the lay public. Information and interpretation from any one of these groups to any other has generally been left to chance.

The Committee recommends that the Institute work for the improvement of communications among the different parts of the mental health field (for example, through conferences and reviews of research) in order to improve the research process–in particular the choice of problems to be studied–and to make broader and more effective use of its findings. (See Chapter VI. C., Knowledge Development, Evaluation, Synthesis, and Utilization.)

C. *Research Priorities.* Several characteristics of past research–in particular the frameworks in which research has been done–are relevant to the Committee's recommendations regarding priorities.

Research in child mental health has been importantly oriented to the view that very early experiences are determiners of later development. Many investigators have pursued an almost single-minded concentration on either infancy or preschool years on the grounds that the problems or opportunities of the child are laid down during these critical periods. Another and related dominant framework of investigation has been the dyadic relationship of child and parent, which has generally been taken as a framework for development–both normal and pathological–without reference to other contexts. Additionally, as pointed out earlier, much clinical and nonclinical research has been culture-bound in problem formulation and research design. Another feature has been the limited development of sound research methods, instruments, and techniques.

These features, along with those discussed as aspects of research quality, have led the Committee to recommend shifts in emphases. In *Table II* (page 30), it has identified dichotomies with a more-than, less-than value to indicate approaches and considerations that should receive more favor in research expenditures.

The Committee suggests that the areas discussed in the following sections are important in child mental health research at this stage of development of the field and should be given emphasis in research supported by NIMH. The Committee's advice is that first-rate work in these areas be encouraged, but it most definitely does not recommend that any absolute priority be assigned these or any other areas. It endorses the recommendation of the Joint Commission that "It is crucial to maintain a wide variety of research and to prevent rigidly defined and limited directions . . . ."

1. *Ecological investigations of child development*

Conceptions and investigations of child rearing and child development are needed that take into account the variety of social matrices in which the child develops. As noted earlier, the traditional model of child rearing research has been that of mother-child dyad in relative isolation from other contexts. But evidence has accumulated that the father-child and the husband-wife relationships also influence child development. And the influence of the broader social context upon adequacy of family care has been shown by findings that

Table II

RECOMMENDED SHIFTS IN RESEARCH EMPHASIS

(more of these)	>	(relative to these)
Basic research[1]	>	Applied research
Developmental designs—short or long term	>	Cross-sectional design
Methodological research on validity and reliability of measures, standard language and procedures	>	Uncritical acceptance of, and proliferation of techniques without facing validity and reliability issues
Toward cumulative knowledge, programmatic strategies of research	>	Fractionated work, with regard to research question, techniques, samples
Reuse of data; data storage; data banks	>	One-time use of data
Useful communication in the planning and execution of research and in making known its results	>	Isolation of investigator's work (a) from work of other investigators (b) from communication (both to and from) the practicing professions and society
Comparative research—cross-species, cross-group, cross-national, cross-cultural	>	Unique happenstance samples as the basis of broad generalization
Ecological, contextual considerations in child development	>	Child development without reference to context or in dyad context only
Multivariate designs	>	Univariate designs
Replication, verification of findings	>	A one-time, one-sample study as the basis of generalization

[1] This preference does not, of course, apply to the demonstration and evaluation programs recommended in other chapters of the report.

both the stresses experienced by the mother and the absence of social support are significantly related to child neglect and abuse. However, theories and empirical data concerning the impact of social structures, physical environments, and cultural values and practices on children's learning, feelings, and performance contain critical gaps. One problem is that such concepts as poverty environments, social class, youth culture, rural-urban differences, and minority group culture tend to be considered only globally in research. They need to be dealt with analytically in finer units or variables. Also needed are theories and research designs that entertain many more interactive influences on development and behavior and that search out the impact of the many diverse frameworks in which child behavior occurs.

2. *Nonintellective aspects of development*

In recent years emphasis has been placed on research on the cognitive development of the young child; nonintellective aspects have not received

similar systematic consideration. Research should be extended to include more investigation of processes of personality development, of affective aspects of development, of the development of motives and values. Research is needed also into the factors involved in the development of ego competence and of adaptive coping mechanisms. The development of social values and social orientations is little explored. The interrelations of intellective and non-intellective processes need study. In the midst of concerns about pathologies and failures, research interests in the positive, integrative aspects of child development—imagination, creativity, prosocial behaviors—should not be lost.

3. *Biological-behavioral research*

A number of important problems require the joint concern of the behavioral sciences and such biological disciplines as genetics, neurophysiology, and biochemistry. Biology and environment do not work independently of each other. A major research task is to disentangle the various influences and understand their interaction. Noteworthy problems include the genetic and environmental interactions involved in the development of such abnormalities as autism or childhood schizophrenia, and the factors that make some children from high-risk groups or deprived environments resistant to typical stresses and able to cope adequately.

Biological and behavioral variables converge in another area relevant to child mental health—the effects of growing up with mentally ill parents. With higher hospital discharge rates for mental patients and with new mental hospital policies, increasing numbers of children are exposed to the effects of incipient, ambulatory, and relapsing psychoses in their parents.

Interrelations of physiological factors and behavioral manifestations at critical maturational stages also need investigation.

4. *Problems of adolescence and youth*

Relative to the amount of research energies directed to early childhood, very little basic research has been directed toward understanding the origins of and influences on behavior in adolescence and youth. To some extent, experiences critical in shaping child development and interventions significant for reshaping development have been identified in the very early years of childhood. Understanding of significant influences in later stages of development remains to be gained. Theories of early influences are not sufficient to explain or predict the directions of behavior in later childhood and youth. More needs to be known about the development of attitudes toward self, the development of identity in adolescent and adult roles, the impact of social disorders upon adolescence, and the development of feelings of alienation and rebellion. What are the characteristics of earlier development, of family relationships, and of social contexts in which adolescents attain positive relationships and orientations, in contrast to those in which conflicts, apathy, distrust, and pathology result? Youth culture, many aspects of which have changed rapidly in the last decade and are continuing to change, is a research area of great practical importance.

5. *Baseline indicator research*

The prevalence and characteristics of child disorders and problem situations are not known. Reliable information on the extent of mental disorders of

childhood in various segments of the population and on changes in rates of disorder over time is lacking. The methods and circumstances under which children are reared have been studied very little. Information on these subjects would be valuable for program planning and for evaluating efforts to deal with mental disorders. It would also help to define what needs to be explained by further research.

Epidemiological research poses very great technical problems, particularly in developing adequate indicators, requires large samples and is therefore expensive, and for maximum utility should be repeated at intervals because incidence measures are far more valuable than prevalence measures and because repetition is the only way that change can be measured. Hence, a commitment to such research means a willingness to support, over a long period of time, a very difficult, unglamorous, and expensive type of endeavor.

Difficult as are the problems of essentially descriptive epidemiology, analytic epidemiology—that is, research that goes beyond describing the incidence of disorder in various population groups to formulate and test hypotheses about why such differences occur—is even more demanding. Moreover, it tends not to be done: the people who do descriptive epidemiological studies generally do not carry out analytic research, and others are not likely to be sufficiently aware of what has been learned in the epidemiological studies. But the potential value of analytic research in preventing disorder is enormous. The Institute can do much to encourage the needed endeavors.

6. *Intervention techniques and programs*

More effective and efficient methods of intervention need to be developed. This means among other things that better use must be made of research findings. It also means that more emphasis must be placed on evaluation. Evaluation is especially difficult research from both conceptual and engineering standpoints. Yet without sound evaluation, the field tends to gain little understanding from programs for intended change. Evaluations of these need the best of research talents and methods. Planning of intervention procedures should include sensitive planning for evaluating them.

7. *Methodological research*

The usefulness of research findings is governed in part by the methods for obtaining data and by the frameworks for interpreting data. In most mental health research, inadequate methodology presents hazards and barriers. Hence, it is important that the Institute, in the process of shifting priorities to child mental health, recognize that the ability of research to meet the needs of social problems depends on the continued attention of skilled investigators to the basic tools of research. Methodological questions include processes of gathering the raw data, of devising analytic procedures, of developing standardized instruments. In the clinical area—where the need for improved research methods is critical—there is need for developing improved early screening procedures for identifying disorders and maladaptive behaviors and for developing diagnostic and prognostic indicators so that the problem and the remedial technique can be matched.

Implementation of Research Priorities

In reaching its conclusions on research priorities, the Committee was guided by this basic belief: That the behavioral science disciplines need to be responsive to the urgent needs of society but—in order to meet these needs truly and most quickly—need to be responsive without sacrificing the safeguards and skills of basic scientific inquiry. The Committee feels strongly that investigators, as well as administrators of research, should strengthen their efforts to learn how to improve research. But this feeling is not mingled with despair. And its expression does not connote a lack of respect for the substantial core of research evidence that has been accumulated. The Committee regards policies of administering research as very critical forces in the shaping of research to come. If these influences are to be facilitative, administrators need to be very sensitively attuned to the effects of freedoms and controls.

What are the best administrative mechanisms for obtaining high quality child mental health research? The most obvious way to get research done in particular areas is to earmark funds for those areas. The Subcommittee on Research felt that this procedure was unnecessary and possibly counter-productive. It took the position that the Institute has the ingenuity, and the research disciplines the resourcefulness, to promote and develop research in the child mental health domain that will be equal in quality to research in any other area without specific earmarking. The Subcommittee expressed this philosophy:

> If NIMH makes, to the research world, a forthright statement of its substantive research priorities, explicitly recognizing the current realities of social needs and limited funds, and, further, if NIMH, with candor, expresses its judgment about the overriding importance of quality, the best and the most responsible scholars will respond positively and productively, and the society will obtain the most from research.

The full Ad Hoc Committee on Child Mental Health approved this expression and adopted it. However, the full Committee believes that grant funds should be earmarked for research on subjects related to child mental health.

The Committee recommends that the Director request the research granting divisions to develop plans for earmarking at least 50 percent of the money available for new research grants beginning with fiscal year 1972.

The Committee also recommends that the Institute:

1. Encourage and invite investigators to submit research proposals in the recommended areas and actively solicit proposals in areas of highest program need. This applies to both basic and goal-directed research. The proposals should be evaluated by the existing system of review—Study Sections composed of active researchers. These review boards should be peopled by investigators recognized for excellence by their disciplines; some but not all of them should be in the field of child mental health as defined earlier in this chapter.

2. Develop mechanisms for bringing expert aid to investigators who have promising proposals or unique opportunities for research. These mechanisms should be used to bring such aid at the point of planning research, prior to the review process. Such mechanisms would serve, among other purposes, to foster research by members of minority groups.

The Committee believes that these proposals will result in a greater emphasis on child mental health research at no loss and very probably a gain in the overall quality of the NIMH program. It further believes that adding to the existing review panels members who are knowledgeable and enthusiastic about child mental health will enrich all research, and that it will keep child research in the mainstream of the psychological, social, and biological sciences.

VI. SPECIAL ISSUES

The Committee has attended to a number of important issues concerning child mental health that do not exclusively relate to any single program area discussed in the preceding chapters. Rather, these special issues cut across all NIMH program interests in child mental health. They include several subjects that have had some mention earlier—the necessity for program collaboration, the great promise of child advocacy programs, and the need to develop, evaluate, and synthesize knowledge and put it to use. They include also the role of minority groups, a subject obviously relevant to all Institute programs, and the need for establishing standards for all NIMH-supported work in the service of children and for checking on the adherence to these standards. Finally, the special issues include the basic one of how to fund the vitally needed work in child mental health.

In the following sections these issues are discussed and the Committee's recommendations presented.

A. PROGRAM COLLABORATION

No other objective of the Institute better illustrates the need to develop and use collaborative modes of operation than that of improving the mental health and preventing the mental illness of children. Collaboration at all levels among agencies concerned with different facets of child mental health can result in a level of services greater than the sum of their individual efforts. Although the Institute's own financial and manpower resources are relatively small in relation to the task of raising significantly the level of child mental health, NIMH can play an important role as an initiator and partner in collaborative activities.

This subject was discussed in Chapter I where examples are given of fields in which collaboration is especially important. The overall goals of these collaborative activities would be:

1. To improve the quality of the physical and psychological environment in which the child develops;
2. To anticipate and ameliorate the stress which accompanies significant events which occur in the lifetime of each child from birth to adulthood; and
3. To combine the many resources necessary for effective rehabilitation of children and their families.

To affect the environment in which children develop from earliest infancy, access is required to organized social institutions such as the family and the schools which serve normal children and to such institutions as the welfare and juvenile justice systems which respond to the needs of children in trouble.

To be effective, the caretakers of these environments must be enlisted on behalf of the populations for which they carry a degree of responsibility. Child development must, therefore, be influenced through the personnel and activities of, on the one hand, basic social institutions such as the family, the school, and the church and, on the other hand, institutions established to help those requiring special assistance such as welfare, social services, courts, probation, police, and public and private health personnel.

An ideal child mental health program enlists the help of all such agents in a preventive mental health effort while at the same time making available to them the specialized skills and resources of the mental health field.

It is of utmost importance that NIMH adopt as an objective early initiation of such collaborative programing. The total program of collaboration must be viewed as a long-range effort. There are, however, a relatively small number of particularly critical intervention points where present efforts can be intensified and new relationships initiated.

To implement the process of collaboration, *the Committee recommends that NIMH:*

1. Aggressively seek to establish collaborative relationships to strengthen child mental health programing. These efforts should begin with the following Federal agencies: Office of Education, Social and Rehabilitation Service, Department of Justice, Office of Child Development, Department of Housing and Urban Development, Office of Economic Opportunity, Department of Labor and, within the Health Services and Mental Health Administration, the Maternal and Child Health Service and the National Center for Family Planning Services. Collaboration with such agencies on the Federal level can be a powerful stimulus toward collaboration among agencies on the local and State levels.

2. Coordinate the grant activities of all Institute divisions and study sections with other Federal agencies which administer grants related to or overlapping subject matter of concern to NIMH.

3. Assign major responsibility for implementing the collaborative program to the Office of Program Liaison, (to establish contacts with other Federal programs), the Office of Program Planning and Evaluation, (to initiate collaborative intermediate and long-range planning activities), and the Center for Studies of Child and Family Mental Health. It is recommended that these three units begin immediate negotiations to this end.

These collaborative efforts should be directed to accomplishing two objectives:

1. Coordination of those services furnished by mental health and other agencies which must be combined to ensure an effective child mental health program, and

2. Planning programs to meet the future needs of the population NIMH shares in common with each of the other agencies.

To ensure success, the following guidelines are suggested:

1. The common program objectives of NIMH and a collaborating agency should be approached by the two agencies involved, e.g., NIMH and the Office of Education, or NIMH and the Department of Justice. The Committee believes that collaborative efforts should begin on a bilateral basis as the most workable and productive approach. There is, of course, a necessary place for a multi-agency forum to share information, but the Committee sees this as a charge of the DHEW Office of Child Development.

2. Before initiating collaborative activities, approval should be obtained from both the Director of NIMH and the director of the collaborating agency.

3. To ensure success, before initiating a collaborative program with another agency, commitment should be obtained for necessary staff and financial resources.

4. All appropriate administrative and program staff from the collaborating agencies should be involved from the start.

5. Adequate time should be allowed for defining common objectives, developing mutual trust, and planning joint actions.

6. It should be recognized that the collaborating agency may have different priorities, mandates, needs, biases, and decision-making processes from the Institute. These should be understood and respected.

7. It should be recognized, too, that collaborating agencies are colleagues and equals. The Institute has at least as much to learn as it has to teach.

Collaborative planning between agencies can be initiated by the simplest and most direct contacts. Wherever two agencies share the same goals in serving a population in common, there is a reason for collaboration.

B. CHILD ADVOCACY PROGRAMS

Children and young people, having no vote, are in a difficult position to exert leverage on those institutions which, for better or worse, have an impact on their growth and development. Most other American populations have at least the potential of developing their own advocates. Specific recommendations for involving youth in influencing NIMH programs are contained in Chapter II (Prevention) and Chapter III (Services). The Joint Commission on Mental Health of Children introduced the concept of child advocacy as a way to help meet the range of children's needs.

Evidence that the well-being of the child is highly related to the well-being of his family suggests a need for an advocacy program that includes the family as well as the child. Further fragmentation of services by planning for child services apart from the needs of the family would probably have limited usefulness. In a family and child advocacy program, the professions would use their skills to support family and community responsibility and control, and the human service agencies and institutions would provide services to families and communities. In the current approach to child services, the professions and institutions assume responsibility and control without adequate representation of families and communities.

Types of Child Advocacy Programs

Advocacy programs can differ widely in their structure and mode of operating—in fact, will have to differ widely if the advocacy concept is to be well tested. The Committee has discussed a number of types, including the following:

1. *Family Child Advocacy Program.* This approach, developed by a subcommittee of the ad hoc committee, is defined as a consumer-controlled outreach system with two major objectives: to obtain more responsive, adequate, and effective service from child and family service agencies; and to develop the strengths, skills, and initiatives of families and communities to solve their own problems. Essential elements would include: analysis of the needs of children, families, and the community—and development of a system of human services; and emphasis on family-centered preventive mental health programs. The program would be directed by a council of parents and community leaders who would employ a qualified person—with a master's degree or equivalent experience in human services—to operate the program. This director would employ a staff of family and child consultant supervisors to lead small teams of family and child consultants who would work directly with families. These family and child consultants would be indigenous paraprofessionals whose training would be based on an academic career ladder model. The director and staff would serve as advocates for the families and

2. *Community Advocacy System.* In this approach, professional nonprofessional persons specifically designated as "child mental heal advocates" would be assigned on a full- or part-time basis to function with various child-serving agencies—health, mental health, education, recreatio criminal justice, and so on—as "consciences" of the agency in relation to chi mental health. They would seek to modify the practices and procedures individual agencies as necessary and to improve the coordination amo different agencies. Although the advocates would be assigned to a variety agencies, they could operate from such bases as a community mental heal center, the mayor's office, or the health and welfare council. At least son neighborhood and community advocates might well be persons in their teer They might have difficulty gaining acceptance within a child-serving agenc but they could be unusually effective in acting as advocates for the needs infants and younger children as well as of their peers.

3. *Child Advocacy Programs at State or Regional Levels.* The approa here is analogous to that outlined under Community Advocacy Syste Possible auspices for State-level advocacy activities include a State-wi committee on children and youth (several of these still exist as a result of t 1960 White House Conference on Children and Youth), the governor's offic or the State mental health authority. Again, the intent would be to modify necessary the practices and procedures of various child-serving agencies with the State.

Recommendations for Child Advocacy Programs

To promote and test the advocacy concept and learn which approaches a best for particular circumstances, *the Committee recommends that t Institute:*

1. Initially develop a modest demonstration program aimed at tablishing the feasibility of neighborhood, community, and State or regio child advocacy programs for the improvement of child mental health. A st toward this goal has already been taken by NIMH in collaboration with t Office of Education's Bureau of Education for the Handicapped. With pooled base of $500,000 the two agencies are seeking to underwrite limited number of pilot child advocacy programs around the country or neighborhood level.

2. Establish an interdivisional committee—including the Center f Studies of Child and Family Mental Health, Division of Mental Heal Service Programs, Division of Extramural Research Programs, and the Offi of Program Liaison—to work out details of the NIMH child advoca program. An ad hoc review committee should be established and wou include persons designated by all of the participating divisions a representatives of the groups most in need of services.

3. Fund by grant a wide range of child advocacy programs over the ne two years. These would be separate from and in addition to those funded

the joint NIMH-Office of Education effort. Place emphasis on the needs of deprived and minority group youngsters. Provide $500,000 for the first year and $1 million for the second.

4. Make every effort to relate ongoing grant-in-aid and technical assistance programs to the proposed demonstration projects in child advocacy. For example, provide that each of the demonstration projects include provision for training of key personnel to staff the project.

5. Play an active role in intradepartmental planning and programing for advocacy programs on a larger scale than these limited demonstration projects.

Recommendations for training in relation to child advocacy functions appear in Chapter IV, Manpower and Training.

C. KNOWLEDGE DEVELOPMENT, EVALUATION, SYNTHESIS, AND UTILIZATION

As a principal social and behavioral science arm of the Federal Government, the Institute has a basic responsibility for the development, dissemination, and use of knowledge about the mental health and mental illness of children. All programs of the Institute share in and must help meet this responsibility. To do so requires continuing analysis and assessment of the state of knowledge, identification of critical gaps, stimulation and support of efforts to fill those gaps, and a wide range of activities concerned with communication of knowledge and its use throughout the field. Because of its history of research, training, and service responsibilities, NIMH is in a unique position to develop knowledge in three areas: the biological and social factors involved in mental illness and health; the recruitment, training, and use of mental health manpower; and services for prevention and treatment, and to work for the widest and most effective use of the findings.

The Committee recommends that the Institute:

1. Ensure the necessary development of knowledge by identifying the areas urgently requiring investigation and by using its resources to further work in these areas. Areas deserving priority in service-related research have been set forth in the chapter on Services, page 16, and those deserving priority in behavioral science research in the chapter on Research, page 29. The Institute should:

   a. Expand or otherwise modify these priorities through consultation with outside specialists;

   b. Use them to guide all its activities related to the accumulation of knowledge.

2. Provide leadership for evaluating and synthesizing all the information—developed by outside as well as by Institute programs—bearing on child mental health. This is perhaps the most critical of the tasks confronting NIMH in the field of knowledge development and use. Though the Institute has devoted resources to it, the approach needs to be stonger and more consistent. Synthesizing activities require a comprehensive overview not only of the research field but also of service and manpower programs. A major role will have to be taken by NIMH staff assigned to this type of work, with outside resources being tapped through contracts, conferences, and applied research grants.

3. Provide leadership for dissemination and utilization. The Institute's effectiveness can be measured by the extent to which existing knowledge is used by program planners and administrators. Though it is important for NIMH to make information available both in English and in Spanish through publications, clearinghouse-type activities, presentations at professional and

scientific meetings, and so on, direct work with key personnel in programs at State and community levels is also required. Workshops like the technical assistance project conferences are one means of reaching leadership personnel. A training college similar to that of the Center for Disease Control is another.

In recent years the emphasis on grant administration, review of proposals, and technical assistance on specific applications has made more difficult and tended to downgrade the importance of consultative activities not necessarily related to specific NIMH grant-in-aid programs. The Institute must find means of legitimizing, sanctioning, and rewarding such activities by members of its staff. Provision of knowledge to other Federal agencies, to State agencies and groups, and to local communities is an extremely important means of developing effective mental health services for children. Especially in view of limitations both of staff and of direct services support funds, it is vital to give this effort renewed vigor and strength.

4. Develop consultative resources throughout the country. The Institute can hope to disseminate knowledge fully only if it develops wide resources able to carry the consultative load with limited assistance from NIMH staff. Consultative skills in child mental health must be developed not only in regional office staff and State mental health departments but also in other State and local settings, including community mental health centers. Conferences, technical assistance projects, and inservice and continuing education activities should be used to help achieve this goal.

5. Assign within the Institute specific responsibility for planning the Institute's program for knowledge development, synthesis, and dissemination. Make the divisions responsible for implementing the program. In each division, one or more staff members should be made responsible for implementing the program within that division and for coordinating the activities of that division with those of the other divisions. Such staff members, though operating primarily as generalists, might well have special areas of interest and experience—for example, early child care, problems in treatment, services for adolescents—they could bring to bear upon their work.

6. Make funds available for synthesizing and disseminating knowledge through such means as contracts, technical assistance projects, and conferences.

D. MINORITY GROUP ISSUES IN RELATION TO CHILD MENTAL HEALTH

The Committee holds with the Joint Commission on Mental Health of Children that:

> The mental health problems of minority group children are so severe that they warrant immediate and drastic attention. Poverty and racism combine to threaten the nutritional, physical, and psychological health of large proportions of oppressed minority group children. Indeed, poverty and racism have created a divisiveness which threatens our future and weakens our society and its citizens. Racism is believed by some to be our Nation's "number one public health problem."
>
> This country must outgrow its legacy of racism. There must be massive outpourings of resources, both financial and human, if the problems are to be resolved. A minority child must grow up seeing himself and his life as having positive value. The white child must grow up learning to judge a fellow human being by what he is, rather than by the color of his skin, and be equipped to live as a member of a multi-racial world. These achievements will allow them both to grow up less handicapped by the effects of guilt, fear, anger, and anxiety.

American health services in general are more available to white middle-class children than to minority group children or the children of migratory workers or the white children of the rural and urban poor. Emotionally disturbed minority group children are more likely to be diagnosed and handled as delinquent or as requiring institutionalization than middle-class white children with very similar symptomatology. The difficulties of most school systems in promoting the education of ghetto and barrio youngsters are well documented. Because of their experiences with the health and education systems of their country, the sense of despair that characterizes vast numbers of minority group youngsters is increased and multiplied.

For NIMH to have any impact on this situation, it will be necessary to encourage institutions which receive the bulk of NIMH funds to increase the involvement of minority group communities and organizations in developing, administering, and operating training, research, and service projects. Promoting this type of activity will greatly increase the impact of NIMH funds.

The Institute's commitment in this area must be more than a "holier than thou" approach to the problem. One important test of the NIMH commitment to combat racism, within itself and within the country, will be the nature of its own activities. Although the Institute has begun special recruitment efforts, devoted itself to Equal Employment Opportunity activities, and established the Center for Minority Group Mental Health Programs, far more needs to be done.

Developing Leadership for Minority Youth

In its service-related and training activities, the *Committee recommends that the Institute:*

1. Stress the recruitment, training, and placement of minority group youths in leadership and policy-making positions within NIMH and in all agencies and institutions having programs impinging on the mental health of children. For the large portion of the child population represented by minority youth, this would be the purest expression of the Institute's often-expressed desire to involve the consumers of mental health services in determining the form and nature of those services.

2. Include minority group members (youth leaders, scientists, staff members, etc.) as part of the decision-making process for NIMH programs affecting minority group children. This would include a prominent role for these minority group members on Institute review committees and other advisory groups.

Training and Minority Youth

In supporting training programs related to child mental health, *the Committee recommends that the Institute:*

1. Give special attention to the problems of minority group youngsters. This is required in the training programs both for mental health personnel and for other human services personnel of child- and family-serving agencies. Minority group specialists, adults as well as youth, who understand the mental health problems of their young people are needed to improve the services and programs of key child-serving institutions such as the schools, welfare departments, juvenile correctional agencies, and health agencies.

2. Support training for minority group mental health workers at both the professional and the subprofessional level. This support should include efforts to provide the consultation and funds necessary to expand training opportunities for minority group mental health personnel in existing training programs. Increasing the number of such workers should make mental health services both more readily available to minority group members and more effective.

3. Instruct site visitors to:

   (a) Make a special effort to determine the number of minority group students in the training programs and on the faculty of the training programs supported by NIMH in the core mental health professions;

   (b) Look for and correct stereotypes regarding black or other minority mental health professionals or patients; and

   (c) Learn whether or not proportionate numbers of minority group members are being accepted as patients by the treatment programs that are part of the training programs. The findings should be taken into consideration in reaching priority rankings for training grants.

Research and Minority Youth

In considering research on the mental health problems of minority group children and on related subjects, *the Committee recommends that the Institute:*

1. Encourage studies in neglected areas, such as:

(a) The prevalence of mental health problems in minority group children and the relation of these problems to pathogenic social conditions;

(b) The impact of race on the nature, dynamics, and course of psychotherapy;

(c) Superior coping by young minority group members;

(d) The adaptive value of so-called deviant behavior in children living in ghetto communities;

(e) Reasons why minority group members are less likely than whites to be accepted as patients in mental health outpatient clinics;

(f) The effects of white racism on white children.

2. Stipulate that research proposals focusing on minority youth have the approval of minority group representatives, and that the proposals ensure that minority group members are included insofar as possible as members of the research project and will be informed of any immediately useful information which the project develops.

Treatment/Preventive Programs and Minority Youth

As a supplement to existing grant mechanisms, such as support for community mental health centers and for Hospital Improvement and Hospital Staff Development projects, *the Committee recommends that the Institute:*

Use demonstration grants to explore new and better ways to provide treatment and preventive services to minority group youngsters. The programs must be tailored to the needs of the community involved, and residents–including young people–must have a key role in their planning and execution.

E. SETTING AND MONITORING STANDARDS

With a few exceptions, establishing and monitoring standards for mental health services has not been considered a primary NIMH role or responsibility. Many staff members, however, have had a keen interest in all efforts to upgrade the quality of care in mental health and other human service programs. But even when standards have been expressed through criteria or regulations for the use of Federal funds, it has been difficult to achieve consensus on interpretation of standards or to find ways of enforcement. In most instances, both standard setting and regulation have been the responsibility of other Federal agencies or of State, local, and voluntary agencies. The incorporation of mental health concepts in these standards has called for intensive efforts at collaboration and communication of mental health values.

Local and State agencies are generally responsible for certifying, licensing, and inspecting various child care facilities–clinics, residential services, hospitals, day care programs–and presumably will continue to have these responsibilities. But increased Federal financing of health and other services brings greater Federal interest in the standards prescribed and the efforts to have them observed. By participating in standard setting and regulatory activities, the Institute can make a valuable contribution to improving child mental health services.

Standards pertain to such matters as physical plant, qualifications of staff, ratio of staff to population being served, economic, racial, or other restrictions (or lack of restrictions) on this population, quality and quantity of specific services, psychological climate or environment, and nature of formal working relations with other agencies.

For an active role in establishing mental health standards for child care facilities and in strengthening regulatory agencies, the Institute will first have to study present approaches and then–through such activities as consultation, education, and technical assistance–work for their improvement. These activities should be undertaken in collaboration with other Federal agencies, national voluntary organizations, State agencies, inter-State compact agencies, and universities.

Several units within NIMH should be involved in the activities–particularly the Standards Development Branch of the Office of Program Planning and Evaluation, the Mental Health Care Administration Branch of the Division of Mental Health Service Programs, and the Continuing Education Branch of the Division of Manpower and Training Programs. They will need additional resources to carry out expanded responsibilities.

As part of its program to ensure that health care programs adequately reflect the mental health needs of children, *the Committee recommends that the Institute:*

1. Help draft minimum standards and regulations for child-related facilities under Federal health care programs.

2. Develop materials for use in training State and local administrative, survey, and licensing personnel for health care programs. The materials should help these personnel recognize environments that are not only physically but also emotionally healthy for children. The Institute should also develop materials to supplement the training of career mental health workers, who may become active in setting standards for mental health care programs and checking upon their observance.

3. Use its influence to help ensure that services in day care and similar programs include attention to the emotional and intellectual as well as the physical needs of children and that standards for such programs are applied alike to those in the private and public sectors.

F. FINANCING CHILD MENTAL HEALTH PROGRAMS

The Institute must find ways to exert leadership in the complex areas of financing health and social services in order to ensure the equitable inclusion and support of child mental health services. To this end it must engage in collaborative and consultative activities with other Federal agencies, with State and local agencies, and with the insurance industry. It must also identify and describe those principles for successfully delivering mental health services that have emerged from NIMH support programs, particularly the community mental health center program. These principles can become the basis for better articulation between planning and financing.

The Committee recommends that the Institute:

1. Establish a high-level continuing group to study the problems of financing mental health services for children.
2. Provide leadership in influencing funding sources to ensure support for child mental health services.

Some of the principles involved in finding support for these services are discussed in the following sections.

Investment and Consumption as a Framework for Discussing Financing

In considering the sources of funding for child mental health services, it is helpful to conceive of two types of outlay of the various monies, excluding for the moment Federal and State funds used for the direct delivery of services through such means as Public Health Service hospitals and State mental hospitals. These major types of outlay are *investment* in the development of capacity to deliver mental health services and *consumption* of the services, which is dependent on purchasing power.

Investment includes all monies past and present spent to develop the capacity necessary for a comprehensive mental health delivery system. Thus, manpower and training grants are investments to influence the system's future capacity. Hospital improvement grants, community mental health center grants, and Narcotic Addict Rehabilitation Act grants influence both present and future capacity. Hill-Burton funds, too, affect present and future capacity.

Consumption is a way of saying how the capacity developed by the investment is utilized. Both the capacity of the system and the funds available to purchase from the system must be considered. Thus, Federal Employee Health Benefits can be used only if the capacity of the system is great enough to provide the services the benefits would buy; if it isn't, the benefits have no utility. Again, an increase in the direct purchasing power of low income groups tends to move them from the public providers of service to the private, at least in the first wave of effort to exercise "consumer choice." This may result in an overload of the private sector; it does not eliminate the need for services by the public sector.

Tables III and *IV* summarize different mechanisms for investment and consumption in relation to major existing and potential NIMH child mental health activities. Three sources of funding are indicated where they apply—project funding, third party payments, and direct service delivery/receipt. Project funding includes grants, front-end funding, and contracts. Third party payments include insurance and Federal payments under Title XVIII (Medicare) and Title XIX (Medicaid). Direct service includes transfer of funds from one agency to another for specific services as well as payments to agencies.

The tables are meant to emphasize the principle that planning for the adequate delivery of mental health services for children cannot be concerned solely with increasing either the capacity to deliver those services or the ability to pay for them.

General Issues in Providing Services Through Health Insurance

In discussing alternative means of financing child mental health services, the Committee paid particular attention to the implications of third-party or insurance mechanisms. A major thrust towards making health services universally available by increasing consumer purchasing power through health insurance will be accompanied by special problems in obtaining equitable coverage of mental health services. Almost without exception, Federal and voluntary health insurance and medical assistance programs have some

Table III

	Investment Sources By Type Of Funding Mechanism And Type Of Program					Private Industry, Individual Contributions, Etc.
	NIMH	Collaboration Funding	Other Federal Agencies	State & Local	Foundations & Philanthropy	
Existing						
Prevention	+	(+)	0	-	+	(+)
Direct Services	+		-	- +		(x)
	x	(x)	x	x	(x)	-
Manpower & Training	+	(+)	(-)	(+)	+	+
Research	+	(+)	(+)	+	+	+
Potential						
Child & Family Mental Health Advocate	(x)	x	x	+ x	+ x	+ x
Staff Consultation & Technical Assistance	(+)	(+)	?	x	0	0

\+ = Project Funding
\- = Third Party
x = Direct Service Delivery/Receipt
0 = None
() = Future
? = Unknown

Table IV

CURRENT SOURCES OF CONSUMPTION BY TYPE OF FUNDING MECHANISM AND TYPE OF PROGRAM

	Out Of Pocket	Purchasing Power					Direct Delivery	
		Voluntary Health Insurance	Federal Health Insurance			Direct Federal Purchasing	Federal	State and Local
			T19	CHAMPUS	FEHB			
Existing								
Prevention	0	0	(+) - x	(+) - x	(+) - x	+ (x)	x	x
Direct Services	x	x	x	x	x	x	x	x
Manpower and Training	0	0	(x)	0	0	0	x	x
Research	0	0	(+)	(+)	(+)	0	x	x
Potential								
Child & Family Mental Health Advocate	x	x	+ x	+ x	+ x	+ x	x	x
Staff Consultation & Technical Assistance	0	0	(+)	(+)	(+)	0	0	0

\+ = Project Funding
\- = Third Party
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limitation on mental health services that differs from regulations for other health services. In addition, insurance payments are usually limited in scope and duration—they do not cover all services for indefinite periods of time. Such limitations certainly will be part of any federally proposed national health insurance plans.

Deductibles and co-payment provisions are also likely to be part of the initial Federal health insurance plans. Deductibles are costs that the patient must bear until a certain minimum amount is reached; co-payment provisions are requirements that the patient pay a certain proportion of costs himself. These two types of limitations are in themselves deterrents to early and effective use of services, particularly in the case of wage earners and low income families. And the deterrents are magnified by the prevailing reluctance to seek help for emotional problems.

Further, increasing the consumer's purchasing power through insurance is not likely by itself to lead to such needed improvements in the health delivery system as better geographic distribution of services, consumer participation in the planning and delivery of services, more effective collaboration between health and other human service agencies, and real continuity of care. In addition, third-party payment systems do not pay for certain essential activities—prevention, planning, health education, advocacy, training, and evaluation.

A number of national health organizations, HEW advisory groups, and consumer organizations have recommended that third-party reimbursement rates to health facilities—such as general hospitals—be linked to requirements that the facility participate in area-wide health planning and in the provision of preventive and other services that are not direct health care.

Another way to help ensure these services is to build them into prepayment plans and other programs—such as group practice plans and Health Maintenance Organizations.

A problem of a different kind is how to protect public providers such as State hospitals from losing State or local appropriations as a result of collecting Federal insurance monies.

Specific Issues in Providing Mental Health Services to Children Through Health Insurance

In addition to the general problems presented above, the Institute must consider a number of specific problems that, unless solved, will limit the capacity of health insurance to finance mental health services for children.

1. The linking of Federal health insurance plans to the father's employment and income level, which seems likely, will probably lead to considerable discontinuity of coverage for persons whose income level changes or who become temporarily unemployed.

2. Most private insurance plans, including many negotiated in labor-management agreements, require an extra contribution by employees to cover their dependents. Children and all other family members will have to be included in new insurance plans if these are to provide purchasing power to

buy the required services. An insurance plan for children without appropriate services to parents would be contrary to current theory and practice in the child mental health field.

3. Benefits under health insurance plans generally are narrowly defined and rarely include the types of educational and social services that have to be an integral part of treatment programs for many disturbed children. Periodic health screening and remedial interventions, although critical for child mental health programs, are also generally excluded from health insurance coverage.

4. Comprehensive child mental health services, as has been emphasized repeatedly in this report, require participation by non-health agencies—education, social services, day care, justice, etc. The mental health components of such programs cannot be strengthened through financing systems that rely primarily on increasing the purchasing power for direct health services.

The Committee recommends that the Institute establish a work group led by the Division of Mental Health Service Programs to study the barriers to effective insurance financing of child mental health services and to recommend how NIMH might influence the establishment of health insurance programs. Staff should be made available from other Institute divisions and offices to participate in this high-level group. Third-party payment plans offer a potential the Institute cannot afford to ignore.

VII. RECOMMENDATIONS [1]

A. Prevention[2]

The Committee recommends that NIMH:

(Family Care)

(1) Support demonstration projects to help parents and future parents obtain a better understanding of the psychosocial aspects of child development.

(2) Develop programs in the schools and other institutions to provide training and supervised experiences in child care to future parents.

(3) Develop materials to prepare high school youth for their marital and parental roles.

(4) Develop innovative training, consultation, and counseling programs to strengthen and support family care.

(5) Develop training methods to emphasize family-centered approaches to prevention and treatment.

(6) Collaborate with other Federal agencies in developing material for family life education courses in high schools and colleges.

(Day Care)

(7) Evaluate and develop models of mental health input into day care programs, in collaboration with other Federal agencies.

(8) Promote mental health input into day care programs through collaboration with other Federal agencies.

(9) Ensure that Federal and State standards set for day care programs include mental health considerations.

(10) Develop mental health training materials for day care workers and those responsible for licensing day care centers.

(11) Collaborate with the Department of Labor on projects to train men and women for day care.

(Schools)

(12) Encourage prekindergarten summer workshops for children and parents.

(13) Support inservice training programs for school personnel that emphasize child mental health considerations.

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[1] Recommendations are listed in the order of their appearance in the report.

[2] The report recommends that in prevention emphasis be placed on family care, day care, the school system, measures relating to young people, the health system, the legal system, and the important role in the community mental health center. The specific items summarized here are examples of the kinds of programs that should be initiated and supported under each heading.

(14) Collaborate with the Office of Education to include mental health principles in teacher training.

(15) Collaborate with State and local boards of education in sponsoring national, regional, and local conferences for teachers and school administrators on current knowledge about child development.

(16) Fund jointly with the Office of Education demonstration projects to prevent learning disabilities.

(17) Use the research grant mechanism to produce information regarding the school's role in the prevention of learning disorders, alienation, racism, and violence.

(Measures Relating to Young People)

(18) Identify and disseminate successful models of college mental health programs.

(19) Place youths under thirty years of age on certain NIMH review committees such as those dealing with drug abuse.

(20) Create more summer job opportunities for youth in NIMH programs.

(21) Convene ad hoc youth advisory councils for NIMH programs directed at young people.

(22) Encourage research projects directed at youth to use some of their staffing funds for youth employees.

(23) Expand research on the factors contributing to adolescent turmoil.

(24) Expand its use of the mass media to present to youth the facts on such problems as drug abuse, suicide, etc.

(25) Consider establishing awards in the behavioral sciences for high school and college youth.

(Health System)

(26) Sponsor research on effective means of disseminating family planning information and collaborate with the National Center for Family Planning Services in their efforts.

(27) Collaborate with the Maternal and Infant Care Programs to disseminate what is already known about providing prenatal and postnatal care.

(28) Develop materials for mothers in the postnatal period.

(29) Sponsor workshops and other training for health workers to emphasize the need for emotional support for hospitalized children.

(Legal System)

(30) Broaden its collaborative activities with the Department of Justice to ensure proper consideration of mental health aspects of law enforcement.

(31) Consider joint funding of research projects on the prevention of delinquency with the National Institute of Law Enforcement and Criminal Justice.

(32) At the regional and State level, disseminate information on the prevention and treatment of delinquents.

(Community Mental Health Centers)

(33) Encourage community mental health centers to actively concer themselves with child mental health in such areas as day car training and job opportunities, etc.

(34) Assign one or more staff members to be responsible for ensuring tha programs with primary prevention effects are given increase attention.

B. Services

The Committee recommends that NIMH:

(Community Mental Health Centers Program)

(1) Require new and continuing community mental health center gran applicants to provide equitable services to children.

(2) Focus developmental consultation for centers on stimulating com prehensive mental health services to children.

(3) Favor construction and staffing grant applications which reflect a emphasis on programs for children and adolescents.

(4) Review existing laws, regulations, and policy statements as t adequacy for a commitment to higher priority for child menta health.

(5) Encourage collaboration between centers and other communit human services.

(6) Request additional resources to:

(a) implement the child mental health provisions of the 197 amendments to the Community Mental Health Centers Act.

(b) enable more rapid implementation of child services through th basic Community Mental Health Centers Program.

(Hospital Improvement Program)

(7) Encourage submission of Hospital Improvement Program gran applications that emphasize children's programs.

(8) Establish review criteria that establish need and require evidence c an interagency planning and programing effectiveness in reducin institutionalization.

(Demonstration Projects)

(10) Identify and evaluate existing innovative efforts that hold promis for model development.

(11) Initiate and evaluate new innovative efforts in community-base child mental health services.

(12) Use existing authority (grants, funds, and staff resources) for:

(a) the required studies, demonstrations, and evaluations.

(b) selectively funding demonstration projects to initiate service

(13) Request increased funds for support of local level demonstrations.

(14) Test a wide range of methods for developing and exercising advocac functions.

(15) Study the developmental, preventive, and treatment implications c early child day care centers and programing.

(16) Explore community-based programing activities that serve as alternatives to community mental health centers and institutionalization.

(17) Explore effective ways to involve youth as staff, consultants, advisors, advocates, and volunteers in the planning and delivery of services for children.

(18) Study ways in which community mental health services can coordinate with other human services such as the school system and juvenile justice system to carry out effective preventive and treatment activities.

C. Manpower and Training

The Committee recommends that NIMH:

(General Principles)

(1) Increase the capacity of training institutions to provide training for mental health professional and paraprofessional personnel which focuses specifically on children's needs.

(2) Place more emphasis on training professional and paraprofessional workers in child-serving fields other than mental health.

(3) Jointly plan and execute training efforts with other NIMH efforts in this area, e.g., advocacy, day care, prevention.

(4) Promote in Institute-supported training programs the development of family-centered and community-centered approaches to child mental health.

(Training Mental Health Personnel)

(5) Give highest priority to strengthening the child mental health component in the basic psychiatric residency, social work, psychology, and psychiatric nursing training programs it supports.

(6) Give preference for new and renewal grants to projects that provide broad training in child mental health.

(7) Expand training programs for new types of child-related mental health specialists.

(8) In considering training programs in the psychological, social, and biological sciences, give preference to the training of investigators who will be particularly qualified to study problems related to child mental health.

(9) Work to make the understanding of child mental health problems and interventive methods a central component of continuing education and inservice training programs supported by NIMH.

(Training Child-Serving Personnel)

(10) Influence to the fullest extent possible the educational institutions that provide the basic professional training of child-serving personnel by:

(a) sponsoring workshops, institutes, and seminars for the faculty of these institutions.

(b) providing financial support to enable these institutions to develop and strengthen their teaching activities related to child mental health.

(c) supporting the preparation of specialized teaching materials.

(11) Expand training opportunities for child-serving agencies by supporting workshops and conferences for their staff and preparing specialized training materials.

(Schools)

(12) Strengthen mental health components in teacher and school administrator training programs.

(13) Develop and assist in funding short-term training for currently employed school personnel.

(14) Develop under contract a "do-it-yourself" package for inservice training of school personnel.

(15) Set aside $750,000 in fiscal year 1972 for support of training programs related to preventive work in schools.

(Day Care)

(16) Develop short-term training for State personnel involved in the licensing and inspection of day care centers.

(17) Support workshops for mental health personnel in a position to provide consultation to day care programs.

(18) Support continuing short-term courses and workshops for training day care personnel, including a "do-it-yourself" package to be used by training institutions in preparing day care personnel.

(Child Advocacy)

(19) Include funds for training activities in the proposed child advocacy demonstration projects.

(20) Assign the development of the training aspects of NIMH-supported child advocacy programs jointly to the Center for Studies of Child and Family Mental Health, the Division of Mental Health Service Programs, and the Division of Manpower and Training Programs.

(21) Work to increase the ability of both professional and "new career" workers in community mental health centers to function effectively as child advocates by:

(a) supporting workshops, seminars, etc.

(b) assisting in preparing teaching materials and curricula.

(22) Emphasize child advocacy approaches in the basic and inservice training of professional and paraprofessional workers in mental health and other child-serving fields.

(23) Support workshops to increase the readiness of people already working in child-serving capacities to include child mental health advocacy among their activities.

(Implementation)

(24) Set aside 50 percent of "free money"—funds available for new projects and for competing renewals—for projects directly related to child mental health training.

(25) Earmark at least $4 million during each of the fiscal years 1972 and 1973 for this purpose.

D. Research

The Committee recommends that NIMH:

(General)

(1) Encourage institutional and individual arrangements that foster intellectual interchange among investigators whose work might impinge on children.

(2) Utilize the findings of basic research for research aimed at improving methods of prevention and treatment.

(3) Place special emphasis on supporting investigators to assess and synthesize existing knowledge, both for the purpose of furthering the scientific disciplines and for assessing the implications of research for program planning.

(4) Make specific provisions for planning and funding short- and long-term longitudinal research.

(5) Support more cross-national and comparative studies of various class and racial segments of American society.

(6) Foster collaboration among individual researchers in different locations with common interest areas and, related to this, seek to improve communications among the producers and consumers of research.

(Research Priorities)

(7) Give the following research priorities special emphasis:
   a. ecological investigations of child development
   b. nonintellective aspects of development
   c. biological-behavioral research
   d. problems of adolescence and youth
   e. baseline indicator research
   f. intervention techniques and programs
   g. methodological research

(8) Earmark for child mental health research at least 50 percent of the money available for new research grants beginning with fiscal year 1972.

(9) Encourage investigators to submit research proposals in the recommended areas and actively solicit proposals in areas of highest program need.

(10) Develop mechanisms for assisting investigators with promising proposals; this includes fostering research by members of minority groups.

E. Program Collaboration

The Committee recommends that NIMH:

(1) Establish collaborative child mental health programs with other

(2) Coordinate appropriate NIMH grant activities with similar activities of other Federal agencies.
(3) Assign major responsibility for implementing the collaborative program to the Office of Program Liaison, the Office of Program Planning and Evaluation, and the Center for Studies of Child and Family Mental Health.
(4) Establish the following guidelines for collaborative activities:
  (a) collaborative efforts should generally be limited to those agencies with direct service inputs.
  (b) prior approval should be obtained from the directors of both agencies.
  (c) prior commitment should be obtained for staff and financial resources.
  (d) appropriate administrative and program staff of both agencies should be involved from the beginning.
  (e) adequate time should be allowed for developing a collaborative program.
  (f) NIMH should understand the different priorities, mandates, needs, etc., of the other agency.
  (g) collaborating agencies are equals.

F. Child Advocacy Programs

The Committee recommends that NIMH:

(1) Announce a limited program of demonstration grants for child advocacy programs with emphasis on the needs of deprived and minority group youngsters.
(2) Establish an interdivisional committee to work out details of the Institute's child advocacy program.
(3) Establish an ad hoc review committee.
(4) Fund by grant a wide range of child advocacy programs over the next two years, providing $500,000 for the first year and $1 million for the second.
(5) Strive to relate ongoing grant-in-aid and technical assistance programs to the proposed child advocacy demonstration projects.
(6) Play an active role in intradepartmental planning and programing for advocacy programs.

G. Knowledge Development, Evaluation, Synthesis, and Utilization

The Committee recommends that NIMH:

(1) Identify areas in child mental health urgently requiring investigation and seek to interest investigators in undertaking studies in these areas.
(2) Assign staff to provide leadership in evaluating and synthesizing knowledge and information on child mental health.
(3) Promote knowledge dissemination and utilization by supplementing such traditional information sources as publications and clearing-

house activities with more focused inservice training and direct work with key personnel in State and community programs.

(4) Identify and develop personnel at State and local levels (including regional office staff) who can increasingly take on key roles in knowledge dissemination and utilization through direct consultation.

(5) Assign within the Institute specific responsibility for overall planning, and identify staff within various programs to perform functions associated with knowledge development, synthesis, and dissemination.

H. Minority Issues

The Committee recommends that NIMH:

(1) Stress the recruitment, training, and placement of minority group youths in leadership positions within NIMH and in other agencies.

(2) Seek a major role for minority group specialists, including youth leaders, in NIMH decisions regarding programs for minority group children.

(3) Focus attention on and expand training opportunities for minority group mental health workers, both professional and subprofessional.

(4) Determine the number of minority group students, faculty, and patients involved in training programs supported by the Institute, so that these factors may be weighed in reaching priority ranking for training grants.

(5) Emphasize research in the following neglected areas:

(a) prevalence of mental health problems in minority group children and the relation of these problems to pathogenic social conditions.

(b) impact of race on the nature, dynamics, and course of psychotherapy.

(c) superior coping by young minority group members.

(d) adaptive value of so-called "deviant" behavior in children living in ghetto communities.

(e) why minority group members are less likely to be accepted as patients in mental health outpatient clinics than white patients.

(f) effects of white racism on white children.

(6) In considering research proposals dealing with minority group children, ensure that minority group members have approved the project, are included insofar as possible as members of the project, and will be informed of any immediately useful information which the project develops.

(7) Supplement existing grant mechanisms with demonstration projects exploring new and imaginative ways of providing services to minority group youngsters.

I. Setting and Monitoring Standards

The Committee recommends that NIMH:

(1) Provide additional resources and responsibilities to branches in tl Office of Program Planning and Evaluation, Division of Ment Health Service Programs, and the Division of Manpower and Trainii Programs for expanding the Institute role in establishing ment health standards and strengthening regulatory agencies for child ca facilities.

(2) Help draft minimum standards and regulations for child-relat facilities under Federal health care programs.

(3) Develop materials for training State and local administrative, surve and licensing personnel for health care programs.

(4) Develop child-related curricula for training career mental heal workers who would become active in setting and regulati standards.

(5) Ensure that day care programs include attention to the emotio and intellectual as well as the physical needs of children.

J. Financing

The Committee recommends that NIMH:

(1) Establish a high-level continuing group to study the problems financing mental health services for children.

(2) Establish a work group in the Division of Mental Health Serv Programs to study the barriers to effective insurance financing child mental health services and to recommend how the Instit might influence the establishment of health insurance programs.

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